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# In The Supreme Court Of The United States

## SHARON JOHNSTON,

*Petitioner,*

v.

## UNITED STATES OF AMERICA,

*Respondent.*

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

## PETITION FOR WRIT OF CERTIORARI

Laura D. Cooper
*Counsel of Record*
ATTORNEY AT LAW
808 Lariat Drive
Eugene, Oregon 97401
(541) 302-6527

*Counsel for Petitioner*

*Dated: May 4, 2009*

THE LEX GROUP$^{DC}$ ♦ 1750 K Street N.W. ♦ Suite 475 ♦ Washington, DC 20006
(202) 955-0001 ♦ (800) 815-3791 ♦ Fax: (202) 955-0022 ♦ www.thelexgroupdc.com

## QUESTIONS PRESENTED

1) In a federal criminal prosecution of a physician under the Controlled Substances Act ["CSA"] for several counts of writing prescriptions "outside the course of professional practice" within the meaning of 21 U.S.C. § 802(21) and 21 CFR § 1306.04(a), did the failure by the federal criminal trial court to apply Florida state law as the controlling constitutional authority for evaluating whether the physician had a "legitimate" medical purpose within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii), constitute a *jurisdictional* error?

2) When a threshold jurisdictional error is assigned for review in a federal appellate court, does that appellate court's failure to address meaningfully that jurisdictional error effectively deprive that appellate court of jurisdiction to issue a merits decision of *any* kind?

3) Does issuance of a federal Circuit Court merits decision in the knowing absence of appellate jurisdiction, or an order to depublish such a decision constitute evidence of judicial caprice requiring an exercise of this Supreme Court's supervisory power?

4) Does the Eleventh Circuit's "invited error" doctrine effectively vitiate a criminal defendant's statutory right to a meaningful appeal when the "error" deemed "invited" otherwise constitutes reversible "plain error"?

## PARTIES

All parties appear in the caption of the case on the title page.

## TABLE OF CONTENTS

**Page**

QUESTIONS PRESENTED ..... i

PARTIES ..... iii

TABLE OF CONTENTS ..... iv

TABLE OF AUTHORITIES ..... viii

OPINION AND DECISION BELOW ..... 1

JURISDICTION ..... 1

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS ..... 1

STATEMENT OF THE CASE AND PERTINENT STATEMENT OF FACTS ..... 2

ARGUMENT ..... 4

Introduction ..... 4

Discussion ..... 5

ISSUE 1: In a federal criminal prosecution of a physician under the Controlled Substances Act ["CSA"] for several counts of writing prescriptions "outside the course of professional practice" within the meaning of 21 U.S.C. § 802(21) and 21 C.F.R. § 1306.04(a), did the failure by the federal criminal trial court to apply Florida state law as the controlling constitutional authority for evaluating whether the physician had a "legitimate" medical purpose within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii), constitute a jurisdictional error? .....5

ISSUE 2: When a threshold jurisdictional error is assigned for review in a federal appellate court, does that appellate court's failure to address meaningfully that jurisdictional error effectively deprive that appellate court of jurisdiction to issue a merits decision of any kind? .....23

ISSUE 3: Does issuance of a federal Circuit Court merits decision in the knowing absence of appellate jurisdiction, or an order to depublish such a decision constitute evidence of judicial caprice requiring an exercise of this Supreme Court's supervisory power? ..... 29

ISSUE 4: Does the Eleventh Circuit's "invited error" doctrine effectively vitiate a federal criminal defendant's statutory right to a meaningful appeal when the "error" deemed "invited" otherwise constitutes reversible "plain error"? ..... 31

CONCLUSION ..... 35

APPENDIX:

Unpublished Opinion of
The United States Court of Appeals for
The Eleventh Circuit
entered March 30, 2009 ..... 1a

Opinion and Order of
The Honorable John E. Steele
Re: Denying Defendant's Renewed
Motion for Judgment of Acquittal
entered April 16, 2008 ..... 18a

Judgment in a Criminal Case
entered July 29, 2008 ..... 21a

U.S. CONST. amend. X ..... 30a

Excerpt of 21 U.S.C. § 802 ..... 31a

21 U.S.C. § 829 ..... 38a

Excerpt of 21 U.S.C. § 841 ..... 40a

21 U.S.C. § 843 ..... 44a

21 U.S.C. § 903 ..... 50a

Fla. Stat. § 381.026 ..... 51a

21 C.F.R. § 1306 ..... 63a

Excerpt of Appellee's Brief in
The Eleventh Circuit Court of Appeals
Record Number 08-14594-HH
entered October 29, 2008 ..... 65a

Court's Instructions to the Jury
entered April 3, 2008 ..... 81a

Indictment
entered August 29, 2007 ..... 93a

## TABLE OF AUTHORITIES

**Page(s)**

### CASES

*Arizonans for Official English v. Arizona*,
520 U.S. 43, 117 S. Ct. 1055,
137 L. Ed. 2d 170 (1997) ..... 25

*Borden v. Paul Revere Life Insurance Co.*,
935 F.2d 370 (1st Cir. 1991) ..... 34

*Dept. of Prof. Reg., Board of*
*Medical Examiners v. Reese*,
Case No. 83-0355, 1984 Fla. Div. Adm.
Hear. LEXIS 4691 (May 12, 1984) ..... 13

*Ex Parte McCardle*,
7 Wall. 506 (1869) ..... 23

*Ford v. Garcia*,
289 F.3d 1283 (11th Cir. 2002) ..... 33

*Forlaw v. Fitzer*,
456 So.2d 432 (Fla. 1984) ..... 13

*Gonzales v. Oregon*,
546 U.S. 243, 126 S. Ct. 904,
163 L. Ed. 2d 748 (2006) ..... *passim*

*Great Southern Fire Proof Hotel Co. v. Jones*,
177 U.S. 449, 20 S. Ct. 690,
44 L. Ed. 2d 842 (1900) ..... 22

*Hoover v. Agency for Health Care Administration*,
676 So.2d 1380 (Fla. 3d DCA 1996) ..... 13

*Hormel v. Helvering*,
312 U.S. 552, 61 S. Ct. 719,
85 L. Ed. 1037 (1941) ..... 33

*Hughey v. United States*,
495 U.S. 411, 110 S. Ct. 1979,
109 L. Ed. 2d 408 (1990) ..... 16

*Johnston v. Dept. of Prof. Reg., Board of Medical Examiners*,
456 So.2d 939 (Fla. 1st DCA 1984) ..... 13

*Juidice v. Vail*,
430 U.S. 327, 97 S. Ct. 1211
28 L. Ed. 2d 376 (1977) ..... 25

*Kircher v. Putnam Funds Trust*,
547 U.S. 633, 126 S. Ct. 2145,
165 L. Ed. 2d 92 (2006) ..... 20

*Maiz v. Virani*,
253 F.3d 641 (11th Cir. 2001) ..... 33

*Mansfield, C. & L. M. R. Co. v. Swan*,
111 U.S. 379, 4 S. Ct. 510,
28 L. Ed. 2d 462 (1884) ..... 24

*McBoyle v. United States*,
283 U.S. 25, 51 S. Ct. 340,
75 L. Ed. 2d 816 (1931) ..... 8

*Mitchell v. Maurer*,
293 U.S. 237, 55 S. Ct. 167,
79 L. Ed. 338 (1934) ..... 17, 25

*Morrison v. Olson*,
487 U.S. 654, 108 S. Ct. 2597,
101 L. Ed. 2d 569 (1988) ..... 16

*Mt. Healthy City Bd. of Ed. v. Doyle*,
429 U.S. 274, 97 S. Ct. 568,
50 L. Ed. 2d 471 (1977) ..... 22

*New York v. United States*,
505 U.S. 144, 112 S. Ct. 2408,
120 L. Ed. 2d 120 (1992) ..... 19

*O'Neill v. United States*,
411 F.2d 139 (3d Cir. 1969) ..... 33

*Osborn v. Haley*,
549 U.S. 225, 127 S. Ct. 881,
166 L. Ed. 2d 819 (2007) ..... 21

*Pate v. Seaboard R.R., Inc.*,
819 F.2d 1074 (11th Cir. 1987) ..... 33

*Printz v. United States*,
521 U.S. 898, 117 S. Ct. 2365,
138 L. Ed. 2d 914 (1997) ..... 17, 18, 19

*Steel Co. v. Citizens For A Better Environment*,
523 U.S. 83, 118 S. Ct. 1003,
140 L. Ed. 2d 210 (1998) ..... 17, 18, 20

*United States v. Aguilar*,
515 U.S. 593, 115 S. Ct. 2357,
137 L. Ed. 2d (1995) ..... 8, 15-16

*United States v. Barrow*,
118 F.3d 482 (6th Cir. 1997) .....34

*United States v. Corrick*,
298 U.S. 435, 56 S. Ct. 829,
80 L. Ed. 1263 (1936) .....25, 27, 28

*United States v. Fulford*,
267 F.3d 1241 (11th Cir. 2001) .....34

*United States v. Green*,
272 F.3d 748 (5th Cir. 2001) .....34

*United States v. Griffith*,
301 F.3d 880 (8th Cir. 2002) .....34

*United States v. Hopkins*,
310 F.3d 143 (4th Cir. 2002) .....34

*United States v. Jernigan*,
341 F.3d 1273 (11th Cir. 2003) .....34

*United States v. Jones*,
570 F.2d 765 (8th Cir. 1978) .....13

*United States v. Moore*,
423 U.S. 122, 96 S. Ct. 335,
46 L. Ed. 2d 333 (1975) .....10

*United States v. Olano*,
507 U.S. 725, 113 S. Ct. 1770,
123 L. Ed. 2d 508 (1993) ..... 16, 32, 33

*United States v. Perez*,
116 F.3d 840 (9th Cir. 1997) ..... 34

*United States v. Ross*,
131 F.3d 970 (11th Cir. 1997) ..... 34

*United States v. Smith*,
459 F.3d 1276 (2006) ..... 34

**CONSTITUTIONAL PROVISIONS**

U.S. CONST. amend. V ..... 12

U.S. CONST. amend. X ..... *passim*

U.S. CONST. art. III ..... *passim*

FLA. CONST. amend. X ..... 4, 30, 35

**STATUTES**

21 U.S.C. § 802 ..... 2

21 U.S.C. § 802(21) ..... 5, 6

21 U.S.C. § 829 ..... 2

21 U.S.C. § 829(c) ..... 6

21 U.S.C. § 830(b)(3)(A)(ii) ..... *passim*

21 U.S.C. § 841 ..... 2

21 U.S.C. § 841(a) ..... 1, 3

21 U.S.C. § 903 ..... 2, 11, 13, 22

21 U.S.C. § 843 ..... 2

28 U.S.C. § 1254 ..... 1, 3

28 U.S.C. § 1291 ..... 3

28 U.S.C. § 2106 ..... 33

28 U.S.C. § 2255 ..... 34

42 U.S.C. § 2990bb2a ..... 9, 11, 14, 17

Fla. Stat. § 381.026 ..... 1, 6

**REGULATIONS**

21 C.F.R. § 1306.04 ..... 2

21 C.F.R. § 1306.04(a) ..... 5, 6, 7, 23

**RULE**

FED. R. CRIM. P. 52(b) ..... 32

## OTHER AUTHORITY

Arthurs, Sean, A Foolish Consistency: How Refusing To Review Ford v. Garcia's Invited Error Demonstrates the Eleventh Circuit's Prioritization of Procedure Over Justice, 72 U. CIN. L. REV. 1707 (2004) ..... 34

## PETITION FOR A WRIT OF CERTIORARI

The petitioner, DR. SHARON JOHNSTON, respectfully prays that a writ of certiorari issue to review the decision of the United States Court of Appeals for the Eleventh Circuit entered March 30, 2009 on a direct criminal appeal by Dr. Sharon Johnston following trial and conviction on four counts of violation of the Controlled Substances Act, 21 U.S.C. § 841(a).

## OPINION AND DECISION BELOW

The decision of the United States Court of Appeals for the Eleventh Circuit was unpublished, and a copy of that decision is included in the Appendix, *infra*.

## JURISDICTION

The Eleventh Circuit affirmed the conviction on March 30, 2009. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254.

## CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS

The Appendix to this Petition for Certiorari reproduces:

> The text of the Florida Patient's Bill of Rights and Responsibilities, Fla. Stat. § 381.026. App. 51a-62a.

- The text of the Tenth Amendment to the United States Constitution. App. 30a

- Portions of the text of the federal Controlled Substances Act, including:

  - 21 U.S.C. § 802. Definitions. App. 38a-39a.

  - 21 U.S.C. § 829. Prescriptions. App. 40a-43a.

  - 21 U.S.C. § 841. Prohibited acts A. App. 40a-43a.

  - 21 U.S.C. § 843. Prohibited acts C. App 44a-49a.

  - 21 U.S.C. § 903. Application of State law. App. 50a.

  - 21 C.F.R. § 1306.04. Purpose of issue of prescription. 63a-64a.

## STATEMENT OF THE CASE AND PERTINENT STATEMENT OF FACTS

Dr. Sharon Johnston was convicted following a jury trial in Fort Myers, Florida, of prescribing controlled substances to three undercover DEA agents, all of whom came to her posing as patients claiming to seek relief for chronic pain. Each of the agents falsely represented to Dr. Johnston that they had chronic pain, that they had previously been receiving opioid analgesics for their pain, and that

their pain had been palliated to some extent by these drugs. In each instance, Dr. Johnston physically examined the patients, and derived a diagnosis based upon her training, education, experience, physical examination, and review of pertinent medical records. Dr. Johnston also advised each undercover agent to obtain an MRI. Nevertheless, Dr. Johnston was charged with four counts of violating the Controlled Substances Act, 21 U.S.C. § 841(a) ("CSA"), was convicted by a jury, and is presently incarcerated. The jury at Dr. Johnston's trial was instructed to apply a "national medical standard" based wholly on expert testimony, and the law of Florida played no role in her trial in providing a standard against which to measure the "scope" of professional practice. Dr. Johnston timely appealed from a judgment of conviction entered on July 29, 2008, in the United States District Court for the Middle District of Florida at Fort Myers to the U.S. Court of Appeals for the Eleventh Circuit under 28 U.S.C. § 1291. Dr. Johnston's criminal appellate counsel raised for the first time on appeal to the United States Court of Appeals for the Eleventh Circuit a substantial question challenging the subject matter jurisdiction of the trial court under the CSA. The Eleventh Circuit affirmed the conviction in its opinion dated March 30, 2009 wherein the appellate merits decision failed to address meaningfully that threshold jurisdictional issue on the grounds that the error had been "invited" by trial counsel, and the panel then depublished the resulting decision. This timely Petition for a Writ of Certiorari follows under 28 U.S.C. § 1254.

## ARGUMENT

### Introduction:

Dr. Sharon Johnston comes to this Court having been convicted of a crime that does not exist, by a court without jurisdiction to enter a conviction, and affirmed by a court that did not confirm that it had jurisdiction to do so and – worse yet – blatantly attempted to "bury" its decision through depublication. The fact that the Circuit Court spilled so much ink explaining the "facts" but dishonestly "ducked" the fundamental question of jurisdiction (which challenged the fundamental "standard" by which those very "facts" *could* be measured) -- and then *depublished* the decision -- should itself sound alarm bells to the supervisory review court. This entire proceeding has been indelibly painted with the bright and unmistakable color of unconstitutional outcome-driven caprice.

The conviction was fundamentally unfair from the very beginning for lack of any predictable standard by which fairly to judge the "legitimacy" of the accused physician's medical purpose, which also undermined any determination about what was within the proper "course of professional practice." The proceedings have also been tainted with a fundamental unraveling of *the rule of law* through explicit judicial usurpation of Florida's Tenth Amendment retained constitutional sovereignty to regulate substantive medical practice. This unraveling was exacerbated by the appellate court's use of a deliberately obtuse "invited error" procedural bar which enforced *procedural rigidity at*

*the expense of fundamental justice*, and ultimately produced a *blatantly outcome-driven* decision so intent on affirming an unjust criminal conviction that the appellate court *knowingly* overstepped its own unwaivable appellate jurisdictional boundaries.

**Discussion:**

> ***ISSUE 1: In a federal criminal prosecution of a physician under the Controlled Substances Act ["CSA"] for several counts of writing prescriptions "outside the course of professional practice" within the meaning of 21 U.S.C. § 802(21) and 21 C.F.R. § 1306.04(a), did the failure by the federal criminal trial court to apply Florida state law as the controlling constitutional authority for evaluating whether the physician had a "legitimate" medical purpose within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii), constitute a jurisdictional error?***

This case began with a criminal indictment[1] in a Fort Myers Middle District of Florida U.S. District Court, of physician Dr. Sharon Johnston, under the Controlled Substances Act ["CSA"] for several counts of writing prescriptions "outside the course[2] of professional practice" within the meaning of 21 U.S.C. § 802(21). The CSA purports to criminalize *all* distribution of controlled substances, and simply

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[1] *See* Indictment. App. 93a.

[2] The actual Indictment language used is "outside the scope of professional practice." *Id.*

*excepts* prescriptions issued by a physician for a "legitimate medical purpose" in "the course of professional practice." *See* 21 U.S.C. §§ 802(21), 829(c), 830(b)(3)(A)(ii) and 21 C.F.R. § 1306.04(a).[3]

Dr. Johnston was a duly-licensed Florida physician and all of the charged prescriptions were written during legitimate office visits for undercover DEA agents who *knowingly and falsely* represented to the physician that they had chronic pain.[4] In each instance, Dr. Johnston physically examined the patients and derived a diagnosis based upon her training, education, experience, physical examination, and review of pertinent medical records. Dr. Johnston also advised each undercover agent to obtain an MRI.

The charged prescriptions could only meet the CSA violation criteria if they were *not* deemed issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice" within the meaning of 21 U.S.C. §§ 802(21), or 830(b)(3)(A)(ii) and 21 C.F.R. §

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[3] Every prescription for a controlled substance must "be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04(a). App. 63a-64a.

[4] No application of Florida *state law* could arguably support a finding of criminality based on these facts. Florida Patient's Bill of Rights and Responsibilities, Fla. Stat. § 381.026 (App. 51a) charges the *patient* with the responsibility to provide accurate and truthful information to the physician. Under the federal approach, the innocent physician is placed in the position of being an *absolute guarantor* of patient reports and revelations. *See also* note 8, *infra*.

1306.04(a). Consequently, to be issued in the "usual course of professional practice" a prescription *must* have been issued for a "legitimate medical purpose" within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii).

The ambiguity of the phrase "legitimate medical purpose" within § 830(b)(3)(A)(ii) is critical to an understanding of the nature of the error committed by the trial court, and arises from a fundamental dispute about *who* decides what is "legitimate" in the context of a medical practice. The fundamental dispute presented here is centered upon the unconstitutional nature of *a new judicially-created "national medical standard"* which unlawfully usurps the police power expressly reserved to the states under the Tenth Amendment.

In *Gonzales v. Oregon*, 546 U.S. 243, 269, (2006)("*Gonzales*"), this Court very clearly observed:

> Congress regulates medical practice insofar as it bars doctors from using their prescription writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally. The silence is understandable, given the structure and limitations of federalism, which allow the States 'great latitude under their police powers to legislate as to the protection of lives, limbs, health, comfort, and quiet of all persons.'
> [Citations omitted.]

In fact, the Court stated that the CSA's structure and operation presume and rely upon a functioning medical profession regulated under the *States'* police powers. *Id.* The *Gonzales* Court recognized that the term "legitimate medical purpose" – the lack of which constitutes the statutory crime (see § 830(b)(3)(A)(ii)) – was itself insufficient to describe a criminal act with the particularity required of federal criminal law: the phrase "'legitimate medical purpose' is a generality, susceptible to more precise definition and open to varying constructions, and thus ambiguous in the relevant sense." *Gonzalez*, 546 U.S. at 257 [emphasis added]. Such ambiguity necessarily implicates due process notice principles. "A fair warning should be given to the world in language that the common world will understand, of what the law intends to do if a certain line is passed." *United States v. Aguilar*, 515 U.S. 593, 600 (1995) (*citing McBoyle v. United States*, 283 U.S. 25, 27 (1931)). Given that insufficiently definitive statutory ambiguity, the word "legitimate" *must* refer to something else from which the required *principled* specificity can be drawn.

The precise issue in *Gonzales* was whether an interpretive rule offered by the Attorney General would be accorded judicial deference as providing the required specificity.[5] In declining deference, the

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[5] The interpretive rule declared that physician-assisted suicide was not a "legitimate medical purpose" and therefore not in "the course of professional practice" within the meaning of the CSA. In response, an Oregon physician and others challenged that rule as a means to stave off threatened federal criminal prosecutions of Oregon physicians under the CSA. The *Gonzalez* Court held that the Attorney General is not authorized to create substantive medical policy under his

Court noted that the *only* provision in which Congress *itself* has set a general, uniform *federal* medical practice standard is contained in 42 U.S.C. § 2990bb2a, in which the treatment of drug addicts is specified. *Gonzales*, 546 U.S. at 570-571. Aside from that single provision, *Gonzales* unequivocally held that a *state medical practice standard* must serve as the *sine qua non* of the federal crime because the Attorney General has no "authority to define diversion based on [his] view of legitimate medical practice..." *Gonzalez*, at 262.

However, despite the clear mandate in *Gonzales* to apply a *state* medical practice standard to define the otherwise ambiguous CSA criminal criteria, the judge in this case charged the jury to apply a "national medical standard"[6] as the

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"control," "registration" and "general powers" provided in the CSA. *Id.* at 259-61, 126 S. Ct. at 917-18, 163 L. Ed. 2d at 768-69. Those powers are so limited because he lacks the expertise to create medical policy, which authority within the Executive Branch lies exclusively with the Secretary of Health and Human Services. *Id.* at 293-95, 126 S. Ct. at 936-37, 163 L. Ed. 2d at 790-91.

[6] Jury Instructions, Pgs. 9, 10. App. 88a. The term "national medical standard" does not distinguish between "standard of care" (which is drawn from *tort* law and references professional *norms* the deviation from which constitute varying degrees of *negligence*) and "medical practice rules" (which are the *only bodies of law capable* of marking the outer *boundaries* of the practice of medicine sufficiently to define in a principled manner the terrain of a "safe harbor" in which a physician may operate as a "healer" and enjoy immunity from criminal charges). Tort standards are only capable of defining "bad medicine as conventionally understood" whereas state medical practice rules are capable of defining "drug dealing as conventionally understood." The critical error in using a

"medical standard" in place of a "medical practice rule" is that federal criminal conduct must *not constitute medical practice at all* – not just medical practice with which federal officials, experts, or juries *disagree*. The conflationary use of a *tort* standard here subjected this physician to *criminal charges* for what amounted to *a medical disagreement* which violates the Tenth Amendment *as well as* basic due process "fair notice" principles. In that manner, this "national medical standard" completely obliterates the distinctions between criminal law, tort law, strict liability, professional regulation, and administrative law and the ***courts*** effectively rewrite the CSA to *criminalize all DEA controlled substances medical disagreements*, in specific defiance of both *Gonzales* and *United States v. Moore*, 423 U.S. 122, 122 (1975). The tort-crime non-differentiation is demonstrated here by both the government's and court's normative statements about what Dr. Johnston *should* have done – in their view -- to be a more *careful and thorough doctor*. The newly-created federal DEA "red flags" "standards" used in this case as a wholesale prosecutorial *invention* also provides a startling glimpse into a world in which DEA officials dictate medical practice standards and "red flags" effectively vitiate the treatment imperative. This paradigm changes the fundamental *relationship* of physicians to their patients because physicians become judged not by whether they meet quality of life goals for patients, but rather by whether they adequately further law enforcement aims. In effect, it also turns the entire physician-patient relationship into *a criminal profile*. Second, physicians are forced to adopt an adversarial relationship with their patients without informing them of the change, and patient visits essentially become a form of interrogation. Under this approach, physicians are *not* allowed to simply *believe* their patients; instead, it is the physician's job to detect patient deception. Another radical result of this paradigm is that the *goals* of treatment for *any condition requiring opioid medications* become indistinguishable from the goals of treatment for *addiction*, with the net effect that *all such patients are treated as current or potential drug addicts, who by definition cannot be trusted, and whose interaction with the medication itself needs to be closely monitored and minimized*. This is *precisely* what occurred in this case; the physician was convicted for treating

yardstick for Dr. Johnston's CSA culpability. A "*national medical standard*" in this context is necessarily *completely fabricated because Congress has not defined "medical practice" boundaries*. *Gonzales* confirms that apart from 42 U.S.C. § 2990bb2a, *only state law* is capable of marking *that particular CSA boundary*. Any federal "boundary" offered apart from 42 U.S.C. § 2990bb2a or a state medical practice law is therefore necessarily a *post hoc federal invention*[7] which as applied by a federal

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her patients' *pain by applying the treatment goals and practice standards used for addiction by the government's testifying expert*. In point of fact, she was tried for *trusting her patients*. If this approach takes hold throughout the United States, the physician's function as healer will be irretrievably compromised, and the physician-patient relationship will be forever supplanted with a police state of medicine. It is no stretch to imagine federal prosecutions based on these principles to eventually encompass *all* medical decision-making by a physician.

[7] The federal prosecutorial practice of relying on experts to *establish* a CSA benchmark for a physician prosecution under this same provision is *always post hoc*, and is fraught with such enormous constitutional danger that the practice should be banned outright. An expert is inevitably given more weight than a competing defendant's point of view since the defendant is considered to have a vested interest in the outcome. An expert may choose which aspects of state law serve him well (or do not, as the case may be); as a result, the expert's pronouncements become a complete substitute for state law, in express violation of the CSA preemption provision in 21 U.S.C. § 903. In essence "state law" becomes whatever the expert says it is and there is no guarantee that the expert will convey how well-established such law actually is or is not, or will clearly enunciate and describe the difference between *tort and crime at all*. In essence, an expert cannot be deemed to have standing to represent or stand for a body of state law or state medical regulators, and should only be allowed to provide an *assistance*

court to support a rule of decision therefore also constitutes a *judicially-created federal common law.*

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*adjunct* thereto, *if at all.* This problem is particularly acute at any time that an expert utilizes a "standard" that is materially objectionable as stated or applied *in any way.* Such "evidence" *which becomes a governing legal standard of criminal conduct* ***shifts the burden of proof*** to the defendant to ***disprove that standard, which completely vitiates the Defendant's Fifth Amendment right to silence*** and places the physician in the unenviable position of having not merely to "correct" the prosecutor and expert at trial even though at an *enormous* evidentiary disadvantage based on perceived bias, but also to "persuade" in order to prevail in a *criminal* proceeding, which ***effectively reverses the presumption of innocence***. Even with competing testimony, there are no safeguards in place that can instruct the jury about which of the varying standards they are "offered" are correct. Because this error implicates fundamental questions of separation of powers (and is therefore *jurisdictional* in nature), this is not a choice a jury should be empowered to make to begin with. Nevertheless, these are issues that arise with astonishing regularity in physician prosecutions under the CSA, and they uniformly arise because rogue experts are used to *establish* disputable "benchmarks," as opposed to *explaining* unequivocal state law that is objectively provable. Federal prosecutors should be forbidden from using expert witnesses to "establish" the existence of a benchmark as a violation of federalism, and as an impingement on both the presumption of innocence, and the Fifth Amendment. As a practical matter, courts adhering to state law should not need experts to define CSA terms at trial. To enforce Tenth Amendment limitations, a federal prosecutor should be required either to defer to a decision by a state medical regulator or to proceed with a trial without experts by establishing "drug dealing as conventionally understood." As a third alternative, a prosecutor should be required to offer up state medical practice authority establishing beyond a reasonable doubt that the physician's conduct lacked a "legitimate" medical purpose. Absent such limitations, and given current federal prosecutorial practices, the Attorney General has essentially *appointed itself* as a *de facto* national medical regulator.

Dr. Sharon Johnston was therefore tried and convicted for prescribing "outside the course of professional practice," -- and thus without a "legitimate medical purpose" within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii) – through a *judicially-created "national medical standard."* In upholding a conviction on those terms, both the trial and appellate courts have sanctioned the use of a *lay federal jury* as a complete constitutional substitute for *the Florida* ***state medical regulator***[8] as the deliberative body which effectively defines what constitutes the "legitimate" practice of medicine in Florida, in express violation of 21 U.S.C. § 903 and the Tenth Amendment.

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[8] Florida state medical practice decisions demonstrate the irreconcilable nature of the federal ***criminal*** conviction here. *See, e.g., Forlaw v. Fitzer*, 456 So.2d 432 (Fla. 1984) (per curiam) (prescribing to an addict without a physical exam *not* outside medical practice); *Hoover v. Agency for Health Care Administration*, 676 So.2d 1380 (Fla. 3d DCA 1996) (lack of medical records and high quantities of narcotics were not sufficient bases for a practice violation, and admonishing "draconian" standards of pain management); *Johnston v. Dept. of Prof. Reg., Board of Medical Examiners*, 456 So.2d 939 (Fla. 1st DCA 1984) (prescribing thousands Dilaudid tablets to a single patient during one year medically appropriate); *Dept. of Prof. Reg., Board of Medical Examiners v. Reese*, Case No. 83-0355, 1984 Fla. Div. Adm. Hear. LEXIS 4691 at *9 (May 12, 1984) ("[p]ain control is the most difficult area to quantitate by virtue of the manner in which patients react to pain undermedication"); *See also, United States v. Jones*, 570 F.2d 765 (8th Cir. 1978)(reasoning cited with approval in *Forlaw*, 456 So.2d at 435) (lack of a physical exam and directions to fill prescription at a certain pharmacy alone insufficient for criminal conviction).

As the *Gonzales* Court iterated, there is no Congressionally-authorized "national" medical practice standard that applies to a physician aside from 42 U.S.C. § 2990bb2a for the simple reason that *Congress has not created one*. *Gonzales*, 546 U.S. at 570-571. If a "national medical standard" does not exist to define a federal crime, a federal court cannot simply *create federal common law* as a statutory *substitute* in violation of Tenth Amendment principles. What the Department of Justice has done here is to *regulate by prosecution*; rather than announcing a "national medical standard" by way of an interpretive rule, it has learned the lesson of *Gonzales* and now bypasses regulation altogether by simply applying its idea of "proper" medical practice through *prosecutions* in Article III Courts.

That Department of Justice approach was confirmed by the appellate briefing in this case. The government argued that the *completely new* "national medical standard" jury instruction was not erroneous, even though none of the cases cited by the government address the limitation of *Gonzales*. *See* Government Appellate Brief at 27-29. App. 71a. Instead, the government asserted that *Gonzales* holds *only* that the Department of Justice is precluded from enforcing the CSA in ways that conflict with *explicit* and *existing* state law (in a sort of "reverse conflict-preemption" principle). As a corollary, the federal government asserted it was also *free* to "fill in" or authoritatively "interpret" *state law* and thereby apply a *new federally-created standard* in doing so. *See* Government Appellate Brief at 31. App. 72a. In other words, the government ***simply disregards*** the primary thrust

of *Gonzales* that the Attorney General has no "authority to define diversion based on [his] view of legitimate medical practice..." *Gonzalez*, at 262.

Instead of *regulating* that authority, now a prosecutor simply *exercises it*. By using an "expert" to "declare" what the government deems "sound medical policy" at *trial*, the Attorney General has accomplished precisely that which *Gonzales* expressly struck down. The government's failure to adhere to state law here thus commits the same legal error *in fact* that was *proposed* by the interpretive rule in *Gonzalez* and the instant federal criminal prosecution which applied a federal common law of medical practice to secure a conviction under the CSA thus represents the ***identical*** federal encroachment to Florida as the *Gonzales* interpretive rule represented to Oregon. *See Gonzales*, 546 U.S. at 253-54. Even worse, Dr. Johnston has now been convicted of the *crime* of disobeying that *new federal medical policy* which the Department of Justice had no authority to *create* in the first place (and never bothered to announce in advance).

To the extent that the Attorney General lacks *authority* to regulate -- meaning he lacks authority to create *new* policy, the Attorney General *must necessarily similarly* lack the authority to *prosecute* cases applying those very same *new policies* because due process constraints prevent *current* criminal prosecutions from introducing *new* policies for which defendants have had no prior "notice" that would allow them to conform their conduct to the requirements of law. *See United States v. Aguilar*,

515 U.S. at 600. Thus, Department of Justice prosecutorial authority must *necessarily be more circumscribed* than its parallel Congressional grant of regulatory authority. *Cf Morrison v. Olson*, 487 U.S. 654 (1988) (Independent Counsel are appointed to exercise prosecutorial authority but not regulatory authority).

Article III Courts must expressly repudiate the practice of "regulation by prosecution" as occurred here, and can do so quite effectively by recognizing the *jurisdictional* nature of the error committed.[9] The *existence* of the error consisting of the failure to apply state law was unequivocal given the clear mandate of *Gonzales*. Unfortunately, the error was recognized by neither the trial court nor *any* of the attorneys (including defense counsel)[10] until representation of the defendant by appellate counsel had been undertaken following conviction. However, this was not an ordinary error subject to preservation limitations; instead, the Supreme Court's *own* description in *Gonzales* establishes its

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[9] The rule of lenity demands resolution of ambiguities in criminal statutes in favor of the defendant. *See Hughey v. United States*, 495 U.S. 411, 422, 110 S. Ct. 1979, 1985-86, 109 L. Ed. 2d 408 (1990)). Thus, even if this Court were not to deem the *Gonzales* error to be jurisdictional in nature, if the law actually applied here was *itself* not sufficiently definitive as to provide ample fair warning of the statutory crime, a federal conviction could not be sustainable if *any* reasonable interpretation of the physician's conduct supported that legitimacy.

[10] Dr. Johnston's own trial counsel erroneously agreed to application of a "national standard," an error which is "plain" within the meaning of *United States v. Olano*, 507 U.S. 725, 732, 113 S. Ct. 1770, 1776, 123 L. Ed. 2d 508 (1993). *See infra*.

*jurisdictional nature*: a court which fails to adhere to the state law requirement *tramples upon the Tenth Amendment's express reservation of state sovereignty and thereby exceeds its own* ***authority*** *granted under the CSA*.[11] The statutory authority granted by Congress under the CSA simply has not provided Article III Courts the *authority* to displace a *state's constitutional reservation of sovereign state power under the Tenth Amendment* to regulate the practice of medicine any more than the Attorney General possessed it in *Gonzales*. Consequently, the state "reservation" of the right to define "legitimate medical purpose" within the CSA is a matter of *constitutional authority*, and an *authorized* federal CSA prosecution involving nonadherence to a "legitimate medical purpose" apart from the single federal definition in 42 U.S.C. § 2990bb2a *must necessarily* expressly incorporate the law of the single constitutionally-authorized definitional source: the state. *See Printz v. U.S.*, 521 U.S. 898, 932 (1997). Moreover, a federal court's failure to adhere to *state* constitutional authority in defining the scope of "legitimate medical purpose" *removes the prosecution from its Congressional grant of authority*, which creates a defect in the federal Court's own *Article III subject matter jurisdiction*. *See Steel Co. v. Citizens For A Better Environment*, 523 U.S. 83, 101 (1998)("*Steel*"); *see also Mitchell v. Maurer*, 293 U.S. 237, 244 (1934) ("*Mitchell*")(diversity).

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[11] *See Gonzalez*, 546 U.S. at 253-54; *see also Printz*, 521 U.S. at 932 (1997)(holding federal statute violated state sovereignty and was "categorically unconstitutional" and not subject to *any* balancing analysis).

The critical difference between the nature of this "jurisdictional" question and an ordinary legal question is described in *Steel*: the former is based on constitutional authority and implicates separation of competing constitutional powers, whereas the latter does not. As a consequence, the *Steel* Court noted that when a legal question importunes *jurisdiction*, that

> [m]uch more than legal niceties are at stake here. The statutory and (especially) constitutional elements of jurisdiction are an essential ingredient of separation and equilibration of powers, restraining the courts from acting at certain times, and even restraining them from acting permanently regarding certain subjects. *See United States v. Richardson*, 418 U.S. 166, 179 (1974); *Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 227 (1974).

*Steel*, 523 U.S. at 101. Viewed through the prism of authority and competing constitutional powers, the Court's "state law" requirement in *Gonzales* does not simply clarify one element of proof to make out a CSA violation; instead, the Court describes this requirement clearly in terms of *authority* and describes the resulting tension as one which plays out between separate and distinct *competitive federal and state constitutional powers*. Moreover, the *Printz* Court described at length why federal encroachments on state sovereignty necessarily

demand an inflexible and *categorical* boundary that must be demarcated as inviolable:

> [m]uch of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear 'formalistic' in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

*Printz*, 521 U.S. 933, *quoting New York v. United States*, 505 U.S. 144, 187 (1992). An "inviolable" boundary is by definition *jurisdictional*.

By necessary implication, the *Gonzales* "state law" requirement clearly outlines a system of federalism under which federal encroachment is both inviolable as well as *outside the scope of Congressionally-authorized power*, and such an encroachment functions to the direct detriment of Tenth Amendment reserved state authority which is in direct competition with it. By failing to adhere to the state law constitutional boundary, the proceeding necessarily takes on other errors of

constitutional dimension. For example, by failing to use state law as the definitional benchmark in this conviction, the federal court allowed the prosecutor to charge, prosecute, and convict based on a *noncrime*, and essentially subjugated the constitutional authority of a state medical regulator to a federal lay jury. Any other view of the *Gonzales* error would support the exercise of power "beyond the bounds of authorized judicial action and thus offend fundamental principles of separation of powers." *Steel*, 523 U.S. at 94.

The *jurisdictional* nature of this error is also apparent from other Supreme Court cases discussing missing predicate "jurisdictional" elements, e.g., those things which are *necessary to establish the federal court's delegated Congressional authority under Article III*. For example, in a removal jurisdiction case, *Kircher v. Putnam Funds Trust*, 547 U.S. 633, 126 S. Ct. 2145, 165 L. Ed. 2d 92 (2006), the Supreme Court held that remand by a federal district court for lack of subject matter jurisdiction after removal was proper for a group of securities class action cases that fell outside the *defined Congressional scope* of a statute designed to curtail certain state security class action lawsuits. The Court reasoned that Congressional intent to preclude certain cases simply did not cover the cases remanded; because the cases therefore fell *outside the Congressional legislative grant of judicial authority*, the cases were properly treated as beyond the court's Article III subject matter jurisdiction. Similarly, in the instant case, when the federal criminal prosecutor failed to apply state law, that prosecution exceeded the scope of Congressional

intent under the CSA and *ceased to be "authorized"* under Article III.

Moreover, the Attorney General was not given "unreviewable" authority under the CSA. By way of comparison, *Osborn v. Haley*, 549 U.S. 225, 127 S. Ct. 881, 166 L. Ed. 2d 819 (2007)("*Osborn*") demonstrates the statutory construction that would have been required to shield the CSA state law error from its jurisdictional consequences. In *Osborn* the Supreme Court described the Attorney General's authority under the Westfall Act to certify that a claim filed in state court against a federal employee occurred within that employee's scope of employment. Following such a certification, the United States is substituted as a defendant and the case is removed to federal court. The statute commands that the Attorney General's certification "conclusively" establishes scope of employment for removal jurisdiction purposes; consequently, the Court held that even when the facts upon which that certification is based are later shown to have been in error, the Court is nevertheless not deprived of continuing jurisdiction over the matter. A specific provision attaching statutory conclusiveness to the certification of the Attorney General "differentiates certified Westfall cases from the typical case involving 'jurisdictional' facts; but for that statutory command of conclusiveness, the case [would be] remanded for want of subject matter jurisdiction." Only an express Congressional directive within the statute that the decision by the Attorney General *could not be reviewed* preserved the federal court's jurisdiction.

By contrast, the jurisdictional proof required to establish lack of "legitimate medical purpose" within the meaning of the CSA must be accomplished *with specific reference to state law*. No Congressional "saving" exists in the CSA; in fact, quite the opposite -- the CSA specifically preserves the *state's police power* in the preemption provision contained in 21 U.S.C. § 903.[12] By analogy, when a CSA prosecution fails to employ *state* law to define whether a physician's conduct is outside a "legitimate medical purpose," that prosecution fails to establish necessary jurisdictional facts, and thereby exceeds the *scope of Congressional authority under the CSA* (*e.g.*, it ceases to be "authorized") so that the federal district court is deprived of subject matter jurisdiction under Article III.

As with any other federal proceeding, the revelation to the trial court that jurisdictional "facts" were missing (here, that the federal prosecutor was not using *state* law to evaluate and prosecute the legitimacy of the medical purpose of the physician) should have caused it to undertake a *sua sponte* evaluation of its own jurisdiction, even if not raised by the parties. *See Mt. Healthy City Bd. of Ed. v. Doyle*, 429 U.S. 274, 278-279 (1977); *Great Southern Fire Proof Hotel Co. v. Jones*, 177 U.S. 449, 453 (1900). Further, the necessary action demanded of the Court upon the revelation that the federal prosecutor had encroached upon the state's

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[12] As 21 U.S.C. § 903 clearly demonstrates, it was *never* the intent of the Congress to use the CSA to substitute federal lay juries for state medical boards, nor for federal criminal prosecutions to regulate the state practice of medicine (whose public health interest is better served by licensure proceedings than by forfeiture, bankruptcy, and imprisonment).

constitutional authority is unequivocal: "Jurisdiction is the power to declare the law, and when it ceases to exist, the only function remaining to the court is that of announcing the fact and dismissing the cause." *Id.*, (quoting *Ex Parte McCardle*, 7 Wall. 506, 514 (1869)). Thus, the federal court should have dismissed for lack of jurisdiction when it became apparent that the prosecutor was not relying on *state law* to define the meaning of "legitimate medical purpose" within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii) and 21 C.F.R. § 1306.04(a).

> ***ISSUE 2: When a threshold jurisdictional error is assigned for review in a federal appellate court, does that appellate court's failure to address meaningfully that jurisdictional error effectively deprive that appellate court of jurisdiction to issue a merits decision of any kind?***

The *existence* of what is hereafter referred to as a "*Gonzales*" error – which consists of a court's *jurisdictional* failure to apply *state law* as the benchmark for determining the "legitimacy" of a physician's medical purpose within the meaning of 21 U.S.C. § 830(b)(3)(A)(ii) and 21 C.F.R. § 1306.04(a) -- is *unequivocal* in this case. The Eleventh Circuit acknowledged that this precise issue had been presented by the Appellant as *a jurisdictional issue*. *See* Appellate Decision at 10. App. 11a. Even if the Eleventh Circuit ultimately *disagreed* with Appellant's point of view about whether the error was *jurisdictional* in nature, the appellate court nevertheless had an unwaivable

threshold duty to *evaluate* in some *meaningful* way whether *Gonzales* commands the application of state law, and if so, whether the failure to apply that state law was *jurisdictional* in nature.

The Court's duty to engage in that threshold evaluation is longstanding and well-established under the precedent of this very Court:

> On every writ of error or appeal, the first and fundamental question is that of jurisdiction, first, of this court, and then of the court from which the record comes. This question the court is bound to ask and answer for itself, even when not otherwise suggested, and without respect to the relation of the parties to it. *Great Southern Fire Proof Hotel Co. v. Jones*, [177 U.S. 449] 453 [(1900)]. The requirement that jurisdiction be established as a threshold matter 'spring[s] from the nature and limits of the judicial power of the United States' and is 'inflexible and without exception.'

*Mansfield, C. & L. M. R. Co. v. Swan*, 111 U.S. 379, 382 (1884).

The appellate court could not address the merits of the appeal *without* first meaningfully evaluating that substantial jurisdictional challenge once it had been raised by the Appellant.[13]

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[13] "'[E]very federal appellate court has a special obligation to 'satisfy itself not only of its own jurisdiction, but also that of the lower courts in a cause under review,' even though the parties

Unfortunately, the Eleventh Circuit failed to engage in *any* serious evaluation of its own jurisdiction, even though it *explicitly* acknowledged that the issue was raised by the Appellant:

> We are unpersuaded by Johnston's argument that the alleged error in the jury instructions is jurisdictional. "A jurisdictional defect is one that 'strip[s] the court of its power to act and ma[kes] its judgment vo*Id.*" *McCoy v. United States*, 266 F.3d 1245, 1249 (11th Cir. 2001) (citation omitted). An indictment suffers from a jurisdictional defect when it charges no crime at all, i.e. a non- offense. *United States v. Peter*, 310 F.3d 709, 714-15 (11th Cir. 2002) No

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are prepared to concede it." *Mitchell*, 293 U.S. at 244; *see Juidice v. Vail*, 430 U.S. 327, 331-332 (1977)(standing).

> The appellants did not raise the question of jurisdiction at the hearing below. But the lack of jurisdiction of a federal court touching the subject-matter of the litigation cannot be waived by the parties, and the District Court should, therefore, have declined sua sponte to proceed in the cause. And if the record discloses that the lower court was without jurisdiction this court will notice the defect, although the parties make no contention concerning it. While the District Court lacked jurisdiction, we have jurisdiction on appeal, not of the merits, but merely for the purpose of correcting the error of the lower court in entertaining the suit."

*United States v. Corrick*, 298 U.S. 435, 440 (1936)("*Corrick*")(footnotes omitted); *Arizonans for Official English v. Arizona*, 520 U.S. 43, 73 (1997).

> such situation exists here because the district court had jurisdiction pursuant to a valid indictment charging Johnston with crimes under the CSA. Because the alleged error is not jurisdictional, we conclude that invited error doctrine precludes review of the jury instruction that applied a national standard of care.

Appeal Decision, pages 10-11. App. 11a. The appellate court did not seriously entertain the question and performed no analysis. In fact, the indictment itself does not specify in any way what benchmark is used to define "*scope* of professional practice." Instead, the indictment simply uses an altered version of ambiguous statutory language and does not define the term used with reference to *anything*. In that respect, the indictment *itself* violated the requirement of *Gonzales* by leaving the term "ambiguous in the relevant sense," *Gonzalez*, 546 U.S. at 257, and therefore charged what amounts to *a noncrime*. The appellate court simply *assumed* a valid charging instrument without bothering to look. Nevertheless, even if the indictment itself were somehow deemed legally sufficient, once the prosecution was undertaken and it became clear that the meaning attached to the otherwise ambiguous language in that indictment was being *drawn without reference to defining state law*, then the court had a *sua sponte* duty to evaluate its own Article III jurisdiction.

Without *meaningfully* evaluating the *constitutional* requirements of *Gonzales* and its

application in the case before it, the appellate court simply *assumed* trial court jurisdiction both *attached* and *continued* throughout the proceeding, and issued a decision on the merits of the appellate case on that basis. Unfortunately, in doing so, the Eleventh Circuit *was exercising appellate jurisdiction it never established.* In the face of a substantial appellate question of trial court jurisdiction, appellate jurisdiction is *itself* absent until that question is meaningfully addressed. *See Corrick*, 298 U.S. at 440. Thus, in the case at bar, without first having undertaking a meaningful evaluation of the threshold jurisdiction issue raised by the Appellant, no appellate jurisdiction attached to the merits decision, and the appellate decision was *ultra vires.* Regardless whether the balance of the appellate decision was technically legally correct, the appellate court's failure meaningfully to confirm the existence of its own jurisdiction stripped its federal authority to enter *any* judgment except dismissal for lack of jurisdiction.[14] *See Corrick*, 298 U.S. at 440.

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[14] The Eleventh Circuit failed to confirm its own appellate jurisdiction but nevertheless issued an *ultra vires* merits decision denying review of a substantive legal issue based on *invited error*. In a system of limited federal judicial power, there is *no logical circumstance* in which error of a *jurisdictional* nature should ever be deemed "invited." In the first place, that doctrine *cannot* vitiate a court's *sua sponte* obligation to evaluate its own jurisdiction. If meaningful jurisdiction analysis discloses that jurisdiction is present there is no reason to deny review of the question based on a procedural bar because an intellectually honest decision on the merits will support the same conclusion. However, if that analysis demonstrates a lack of jurisdiction, a court has no jurisdiction to judge the merits of the matter *ab initio* and the case must be *dismissed* (not denied on the merits due to a

It is therefore evident that *compounding federal subject matter jurisdictional errors* have existed in this case from the Indictment forward. Dr. Johnston now essentially stands *convicted of a crime that does not exist, by a court without jurisdiction to enter a conviction, affirmed by a court that did not confirm whether it had jurisdiction to conduct a review; and, worse yet, the appellate court blatantly attempted to "bury" its decision through depublication.* What is missing is ***fundamental justice*** – Dr. Johnston has never truly had her "day in court" as measured meaningfully by constitutionally relevant *state* authority to *define* a crime that is not otherwise "ambiguous in the relevant sense." That ambiguity is the central problem: it allowed the prosecutor and his paid experts to "fill in" whatever newly-created federal common law "medical standards" served his *post hoc* needs, even though the Attorney General has no "authority to define diversion based on [his] view of legitimate medical practice..." *Gonzalez*, at 262.

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purported error of "invited" nature). *See Corrick*, 298 U.S. at 440.

***ISSUE 3: Does issuance of a federal Circuit Court merits decision in the knowing absence of appellate jurisdiction, or an order to depublish such a decision constitute evidence of judicial caprice requiring an exercise of this Supreme Court's supervisory power?***

As demonstrated above, the appellate court in this case "invented" its own appellate jurisdiction in order to issue a ruling on the merits. In that respect, the primary *knowing* judicial error here was committed by the *appellate* court, which failed meaningfully to analyze its own federal jurisdiction but nevertheless issued *an ultra vires decision on the merits of the appeal.*

To make matters worse, however, the Court further departed from any meaningful semblance of the rule of law and transparently attempted to evade or bury the consequences of its own analytic failure by *depublishing* the decision. *Depublication* of a decision in which an *unwaivable jurisdictional* issue was clearly raised and inadequately addressed provides unmistakable evidence of the existence of a parallel *extra-constitutional* body of Circuit law for which the Court is *completely unaccountable* and which is an expression of a form of tyranny by judicial caprice – where Circuit court judges personally decide *without limitation* which rules of law they choose to disregard by simply *depublishing* the resulting decisions. This unsupervised assertion of such unaccountable power will certainly undermine public faith in the integrity of our legal system and "prove" to citizens the existence of an

outcome-driven "convict at any cost" federal judiciary. Absent some *supervisory limitations* on which decisions a Circuit Court may depublish, nothing prevents such Courts from evading issues – even primary questions of jurisdiction – in like manner as occurred here.

As a result, this entire proceeding now has been indelibly painted with the bright and unmistakable color of unconstitutional caprice; the Eleventh Circuit U.S. Court of Appeals has *depublished a transparently dishonest decision on an important jurisdictional issue in the Circuit.* This conviction was therefore not only fundamentally unfair for lack of any predictable standard by which fairly to judge the "legitimacy" of the accused physician's medical purpose from the very beginning, but it was also tainted with a fundamental unraveling of *the rule of law* through explicit judicial usurpation of Florida's Tenth Amendment retained constitutional sovereignty to regulate substantive medical practice, and exacerbated with a deliberately obtuse "invited review" criminal appellate procedural bar which *legitimizes the exercise of procedural rigidity at the expense of fundamental justice.* This ultimately resulted in a *blatantly outcome driven* appellate decision that discloses such a strong preference for affirming a criminal conviction that the panel willingly sidestepped its own unwaivable appellate jurisdiction boundaries to do so.

The appellate court's *first* duty should have been to perform an intellectually honest and searching analysis of the briefed jurisdictional error.

It did not; in fact, it performed no analysis whatsoever beyond parroting hornbook law about the function of a criminal indictment, *assumed* that the charging instrument was valid, and failed to consider the consequences of subsequent vitiation of jurisdictional facts. Had the court performed any meaningful evaluation of the actual issue presented, it would have determined that the failure to cite and adhere to state law as the sole constitutionally-relevant authority for measuring the "legitimacy" of the physician's medical purpose was *outside* the Article III congressional grant of authority under the CSA.

Consequently, both the U.S. District Court and the U.S. Court of Appeals for the Eleventh Circuit have so far departed from their own Article III jurisdiction limitations in this case as well as bedrock principles of fundamental fairness as to call for an exercise of the Supreme Court's supervisory power. Again, it bears repeating – what is missing here is ***fundamental justice***.

> ***ISSUE 4: Does the Eleventh Circuit's "invited error" doctrine effectively vitiate a federal criminal defendant's statutory right to a meaningful appeal when the "error" deemed "invited" otherwise constitutes reversible "plain error"?***

Given the court's *sua sponte* duty to evaluate its own jurisdiction, a jurisdictional error can never be deemed "invited" by a litigant. Nevertheless, even if this Court does not deem the *Gonzales* error to be "jurisdictional" in nature, an honest evaluation

of that issue should have revealed the commission of reversible "plain error." *See United States v. Olano*, 507 U.S. 725, 732, 113 S. Ct. 1770, 1776, 123 L. Ed. 2d 508 (1993) ("*Olano*") (a federal appellate court can correct plain errors even when not preserved at trial). Under the plain error standard, an appellate court can correct an error not raised at trial, if there is (1) error, (2) that is plain, and (3) that seriously affects the fairness, integrity, or public reputation of judicial proceedings. *Id.*

In this case, the law applied by the trial court to define "legitimate medical purpose" directly contradicted existing Supreme Court precedent under *Gonzales* and was therefore "error" that was "well-established" at the time of trial. Moreover, there was no federal "crime" as prosecuted aside from *state* law.[15] Thus, there is also no doubt that the *Gonzales* error seriously affected the fairness of the proceeding. Instead, this physician was convicted in a criminal proceeding in which lines between tort and crime were completely blurred, where expert witnesses themselves become unreliable *primary de jure* sources of "law",[16] and a complicated medical judgment was rendered by a lay jury as a federal substitute for a state medical regulator. Even if the appellate court had determined that the *Gonzales* error was not jurisdictional, the court should nevertheless have reversed on the grounds of "plain error." *See* Fed. R. Crim. P. 52(b).

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[15] *See* notes 4 and 8, *supra*.

[16] *See* note 7, *supra*.

Justice Black's ordering of the rules of justice as superior to the rules of procedure remains a central tenet in the federal appellate structure.[17] In 28 U.S.C. § 2106, Congress directed that, when entering judgment, a court of appeals may affirm, modify, vacate, set aside or reverse any judgment, decree, or order of a court lawfully brought before it for review, and may . . . direct the entry of such appropriate judgment, decree, or order, or require such further proceedings to be had as may be just under the circumstances." Congress did not mention "balance" between procedural mechanisms and the demands of justice; nor did it state that a just result may be foregone in the interests of judicial economy. Instead, Congress delegated to the appellate courts the responsibility for requiring "further proceedings . . . as may be just." *Id.* *See O'Neill v. United States*, 411 F.2d 139, 143-44 (3d Cir. 1969).

Unfortunately, the Eleventh Circuit U.S. Court of Appeals is unique among the federal Circuit Courts in that it *alone* applies an *absolute bar* in a criminal case[18] to any error deemed "invited" by trial counsel even if that error otherwise qualifies as "plain error" under the *Olano* standard. *See Ford v. Garcia*. 289 F.3d 1283, 1294 (11th Cir. 2002); *United*

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[17] Rules of practice and procedure are devised to promote the ends of justice, not to defeat them. "Orderly rules of procedure do not require sacrifice of the rules of fundamental justice." *Hormel v. Helvering*, 312 U.S. 552, 557 (1941).

[18] The Eleventh Circuit has left open possibility of applying an exception, *see Maiz v. Virani*, 253 F.3d 641, 677 (11th Cir. 2001), but has applied such an exception *only* in *civil* cases. *See Pate v. Seaboard R.R., Inc.*, 819 F.2d 1074, 1083 (11th Cir. 1987) (internal quotations and citation omitted).

*States v. Fulford*, 267 F.3d 1241, 1247 (11th Cir. 2001); *United States v. Ross*, 131 F.3d 970, 988 (11th Cir. 1997); *see also* Arthurs, Sean, *A Foolish Consistency: How Refusing To Review Ford v. Garcia's Invited Error Demonstrates the Eleventh Circuit's Prioritization of Procedure Over Justice*, 72 U. CIN. L. REV. 1707 (2004). The primary purpose of the invited error doctrine is to deter defendants from making "an affirmative, apparently strategic decision at trial and then complain[ing] on appeal that the result of that decision constitutes reversible error." *United States v. Jernigan*, 341 F.3d 1273, 1290 (11th Cir. 2003).

Nevertheless, six of the seven circuits that have addressed this issue have cited the primacy of their duty to secure justice and thereby refused to foreclose review of invited errors *altogether*. *See Borden v. Paul Revere Life Insurance Co.*, 935 F.2d 370, 375 (1st Cir. 1991); *United States v. Hopkins*, 310 F.3d 143, 151 (4th Cir. 2002); *United States v. Green*, 272 F.3d 748, 754 (5th Cir. 2001); *United States v. Barrow*, 118 F.3d 482, 491 (6th Cir. 1997); *United States v. Griffith*, 301 F.3d 880, 883 (8th Cir. 2002); *United States v. Perez*, 116 F.3d 840 (9th Cir. 1997).

However, in the face of *plain error*, this *invited error* bar serves neither justice nor judicial economy because the burdens of proof for plain error and ineffective assistance of counsel "overlap significantly," such that, when "the first three prongs of the plain error standard" are satisfied, "counsel was incompetent for not having objected." *United States v. Smith*, 459 F.3d 1276, 1303 (2006)

(Tjoflat, J., specially concurring). In other words, it is nonsensical for the appellate court to apply "invited error" in a case that also constitutes "plain error" because the very application of "invited error" in that situation *proves* that the defendant had ineffective assistance of *trial* counsel. Application of the "invited error" bar by the appellate court under these circumstances completely subjugates the interests of justice to the inflexible demands of a procedural mechanism by holding the criminal defendant accountable for a decision made by a demonstrably *ineffective* *trial* counsel on direct appeal; in reality, this only *multiplies* the work of the courts by guaranteeing that they will have to review this case again on a petition for Habeas Corpus under 28 U.S.C. § 2255 based on the *court's own pronouncement of counsel ineffectiveness.* Thus, even if the Circuit Court disagreed about the jurisdictional nature of the underlying error, it should have applied an exception to the "invited error" doctrine in the face of "plain error."

## CONCLUSION

The ultimate question which has been begged throughout this entire proceeding by the lower courts is *who* decides what is a "legitimate" medical purpose? *No* honest application of Florida *state* law could arguably support a finding of criminality to sustain this conviction, and for that reason federal prosecutors likely expressly avoided it[19] and instead applied a previously nonexistent "national medical standard" to determine *criminality.* By treading upon the State's Tenth Amendment reservation of

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[19] See footnotes 4 and 8, *supra.*

rights to regulate substantive medical practice, the federal court did not exercise a valid Congressional delegation of Article III jurisdiction upon which to base a federal criminal conviction. The jurisdiction of *both* the U.S. District Court *and* the Court of Appeals to enter a judgment of conviction were thus *vitiated* and the decisions were both therefore *ultra vires*; even worse, the decision of the Eleventh Circuit U.S. Circuit Court below *knowingly* evaded its own primary duty to assess its own jurisdiction.

The Eleventh Circuit has now effectively replaced the Florida state medical regulator with a federal lay jury, and having done so it then went to great lengths to synthesize the "facts" of the case in such a way as to rationalize its conviction by making multiple normative judgments about medical care. The decision begs the ultimate question – how the appellate Court [and also the jury] could possibly evaluate medical "facts" in the complete absence of a *jurisdictional* "standard" to begin with? For the sake of individual justice, the basic rule of law in the United States, and in deference to Constitutional *limitations* of federal authority under the Tenth Amendment which have been wholly disregarded here, this Petition should be granted.

Respectfully submitted,

/s/ Laura D. Cooper
Laura D. Cooper
*Counsel of Record*
ATTORNEY AT LAW
808 Lariat Drive
Eugene, Oregon 97401
(541) 302-6527

# APPENDIX

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

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No. 08-14594
Non-Argument Calendar

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FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
MARCH 30, 2009
THOMAS K. KAHN
CLERK

D. C. Docket No. 07-00105-CR-FTM-29-DNF

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

versus

SHARON JOHNSTON,

Defendant-Appellant.

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Appeal from the United States District Court

for the Middle District of Florida

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(March 30, 2009)

Before BLACK, PRYOR and KRAVITCH, Circuit Judges.

PER CURIAM:

The Controlled Substances Act ("CSA"), 21 U.S.C. § 841, prohibits dispensing controlled substances, unless prescribed "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04(a). Dr. Sharon Johnston was convicted for illegally dispensing: Oxycodone (the generic name for Roxicodone) and Alprazolam (the generic name for Xanax) (Count 1); Oxycodone (Count 2); Alprazolam and Methadone (Count 3); and Oxycodone (Count 4) in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).[1] She was sentenced to 30 months' imprisonment on each count, to run concurrently. She now appeals.

## I. Facts

Johnston was an osteopathic physician, specializing in neurology, working in Naples, Florida. In 2007, a medical malpractice investigator with the State of Florida Department of Health received information that Johnston may have been unlawfully proscribing narcotics. She transmitted this information to Amber Baginski, a detective with the Naples Police Department that was assigned to the Drug Enforcement Administration ("DEA") as a task force officer. The DEA instituted an investigation and sent three undercover detectives

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[1] Roxicodone and Methadone are Schedule II narcotics and Xanax is a schedule IV narcotic.

into Johnston's office posing as patients. They were all instructed not to bring any medical files, prescription bottles, or "show proof that they had had any kind of medical exam or had been given any prescriptions." On the basis of the evidence gained from these visits, Johnston was indicted and tried.

The three undercover detectives testified at trial. The substance of their testimony was as follows: Mark Schaible, posing as Marcus Damm, visited Johnston's office on June 11, 2007.[2] Schaible complained of back pain, told Johnston that he was injured while exercising at the gym, and that he had pain radiating down his leg. Schaible told Johnston that he worked in Daytona, but when Johnston commented on the long distance her traveled to see her, Schaible stated that he was staying with his mother in nearby Fort Myers. Johnston told Schaible that he had a "herniated disk back there that's causing all the pain" and that "[s]ooner or later" he would need an MRI, but she did not immediately recommend that he get one done. Schaible testified that certain statements that he made to Johnston were intended to act as "red flags," including: (1) he was previously a patient of Dr. Pizarro, who was under indictment for soliciting sex in exchange for narcotics; and (2) he had been "bumming" medications from his friends. Johnston tested Schaible's reflexes, had him extend his arms and touch his fingertips, and checked his blood pressure. Johnston only looked at Schaible's back when discussing his tattoos. She did not otherwise touch

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[2] Schaible recorded his conversation with Johnston and the tape was played at trial.

his back, perform any other tests, or recommend an x-ray.

Schaible informed Johnston he was taking four to five Roxicodone tablets per day. Johnston replied, "I don't know how much you're getting, or where you're getting it from. Which is fine." Schaible also told Johnston that he was taking two to three 1-milligram tablets of Xanax per day, which Johnston noted was a lot. Johnston commented that Schaible's blood pressure was low, attributing this to the fact that he was probably "nice and mellow" from the Roxicodone and Xanax. Schaible also commented, "I always kind of wondered why you can go into a store and buy a gallon of vodka and a carton of cigarettes, you can have a good time, but you can't take a pain pill." Schaible paid cash for the cost of his visit and left Johnston's office with prescriptions for 150 15-milligram tablets of Roxicodone and 90 1-milligram tablets of Xanax.

Schaible had a follow-up appointment scheduled for July 9, but "to throw up another red flag" he called three weeks after his first appointment, claiming that he ran out of his medication, even though the prescription should have lasted longer. The appointment was moved to July 5. At this visit, Schaible complained that his pain was too high, that the Roxicodone was not working, and that he had been receiving 40-milligram Methadone wafers from his friend. Johnston acknowledged that Methadone is "pretty powerful stuff" and "real hard core," and that moving from 15 to 40-milligrams is "quite a jump." Schaible explained that he took Methadone as often as six times per day, but that he only bought twenty pills

off of his friend because "he needs to make some money too." Johnston did not examine Schaible at all during the visit and wrote him a prescription for 150 40-milligram Methadone wafers and refilled his Xanax prescription.

Amber Baginski, who posed as Amber Needles, was the second patient in the investigation. She testified that on June 27, 2007, she arrived at Johnston's office and noticed that several patients in the waiting room appeared to be high. Baginski was taken to an examination room, where she met Johnston.[3] She told Johnston that she had been a patient of Dr. Pizarro and that, due to general back pain, she had been taking 15-milligram Roxicodone tablets.[4] Johnston asked whether Baginski had fallen or been in an accident, and when Baginski said no, Johnston responded that most patients tell her the pain resulted from one of these incidents. Johnston checked Baginski's reflexes, blood pressure, and had her touch her fingertips, but did not examine Baginski's back or perform any other tests. As Baginski held out her hands, Johnston asked, "Doesn't the pain radiate down your legs?" Baginski believed Johnston was "telling me what I needed to say in order to obtain the pain medication." When Baginski confirmed that the pain radiated, Johnston gave her a prescription for 90 15-milligram tablets of Roxicodone. According to

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[3] Baginski carried a recorder, but the device malfunctioned and therefore no tapes were presented at trial.

[4] Johnston did not request any of medical records, but did recommend that she get an MRI. Even though Baginski had insurance, she declined, stating that it was too expensive. Johnston did not inquire further.

Baginski, the entire examination lasted less than five minutes.

Donald McDougall, who posed as Donald Nieczticz, was the final patient in the investigation. On July 10, 2007, he visited Johnston's office, where he explained to Johnston that he had experienced pain in the past, but was not currently suffering any pain.[5] Johnston asked if McDougall had an MRI and he told her that although he had, it did not reveal anything. McDougall told Johnston that he had a doctor near his home in the Florida Keys and that he was currently taking 20-milligram Oxycontin tablets, to which Johnston replied, "you can't take that. You're overmedicated." Nonetheless, Johnston did not follow-up about the distance McDougall traveled to see her, the name of his regular physician, or when he last had his prescription filled. As with the other patients, Johnston tested McDougall's reflexes, checked his blood pressure, and had him hold out his arms and touch his fingertips, but did no further examinations. McDougall testified that most of the fifteen-minute examination was spent discussing fishing and real estate. At the close of the visit, Johnston prescribed 90 30-milligram tablets of Roxicodone, 90 100-milligram Neurontin, and 60 pills of Flexeril.[6]

Johnston's office manager testified that Johnston used pre-printed examination forms to save time; Johnston would then cross out whatever

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[5] As with Baginski, the recording device malfunctioned and therefore no tapes were presented at trial.

[6] Neurontin and Flexeril are prescription pain killers and muscle relaxers, but are not covered by the CSA.

information was incorrect after she examined the patient. About 99 percent of Johnston's pain management patients received controlled substance prescriptions.

The government called two expert witnesses: Dr. Richard Hood and Dr. Sherri Pinsley. Hood testified as to the high strength of the drugs prescribed by Johnston and their many potentially dangerous and deadly side effects, especially when taken together or with alcohol. He testified that a doctor should not increase from a low dose of Roxicodone to a high dose of Methadone based solely on a patients' claims that Methadone is more effective for him than Roxicodone. Instead, a doctor could confirm what drugs a patient was using by urinalysis, obtaining medical records, or obtaining past prescription bottles. Hood also explained that a patient illegally buying prescription drugs is a "red flag . . . [for] diversion and addiction." Finally, Hood testified that normally if a patient complains of back pain, a doctor should palpate the back to see if it elicits muscle spasms or tenderness.

Pinsley testified that in her pain management practice, an initial patient visit would include a head-to-toe examination, including range of motion exercises and palpating the vertebras of the spine. Pinsley testified that she would only treat a patient after obtaining the patient's medical records and, if the patient had not undergone any tests, she would require an MRI or x-ray be conducted.[7] Pinsley said

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[7] Pinsley testified that she would sometimes give prescriptions that were of limited quantity and dosage until she could obtain the records or get tests done.

that controlled substances are always her last resort and, before prescribing controlled substances, she requires patients to take a toxicology test so that she can confirm whether they are taking any medication. She testified that Johnston's patient files were sparse, that her exams were limited, and that she was concerned that Johnston prompted patients to give certain answers about pain. She noted that she was troubled by the red flags raised by the undercover agents, including traveling a long distance to see Johnston, lack of previous medical records or tests, buying medications illegally, and requesting more medications too quickly. In her opinion, Johnston prescribed stronger medications than appropriate and acted outside the scope of professional practice.

Johnston's case included testimony by her own expert, Dr. Thomas Romano. Romano was of the opinion that Johnston's conduct was professional and consistent with standards of professional care in the United States. Romano explained that there is no objective test for pain and that a doctor has to listen to a patient's report of pain and rely on her own judgment in determining whether the patient is reliable. Romano acknowledged that some of the statements made by the detectives could be red flags, but noted that there could be legitimate explanations for each that would not have prevented a doctor from treating a patient. Romano opined that Johnston acted in good faith in prescribing the medications to the three patients.

The jury ultimately convicted Johnston of all charges. Johnston appeals to this court, arguing that the district court erred by: (1) applying a national,

rather than state-specific, standard of care; (2) admitting prejudicial "red flags" evidence and permitting the government's experts to testify to legal conclusions based on the red flags; and (3) denying Johnston's motion for acquittal on the ground that the government did not prove that Johnston acted with the requisite mens rea.

## II. Discussion

### A. National standard of care

A doctor may not be convicted under the CSA for issuing prescriptions to patients unless the doctor failed to act in good faith and for a legitimate medical purpose. United States v. Merrill, 513 F.3d 1293, 1301-02 (11th Cir. 2008). Johnston acknowledges this standard, but argues that the district court erred by instructing the jury that it should apply a national standard of care in determining whether Johnston failed to act in furtherance of a legitimate medical purpose. Specifically, Johnston takes issue with the district court's instruction that, "a physician's mere subjective personal belief that she is meeting a person's medical needs by prescribing a controlled substance is not sufficient to show good faith if the physician acts outside the accepted standard of medical practice in the United States" (emphasis added). Johnston argues that under Gonzales v. Oregon, 546 U.S. 243 (2006), state medical standards should be used to determine whether a doctor acted in conformance with accepted medical standards for the purposes of the CSA. Johnston argues that by failing to instruct the jury that Florida's standard of care governs, the district court

committed reversible error. Moreover, Johnston argues that this error is jurisdictional and therefore should be review de novo.

Where a party properly objects to the jury instructions, we review the legal correctness of a district court's jury instruction de novo and issues of phrasing for abuse of discretion. United States v. Prather, 205 F.3d 1265, 1270 (11th Cir. 2000). Ordinarily, if the complaining party fails to object, we review for plain error. United States v. Schlei, 122 F.3d 944, 973 (11th Cir. 1997). A party waives the ability to contest the propriety of the instructions, however, if the party invites the error by requesting the substance of the instructions that she later seeks to challenge on appeal. United States v. Stone, 139 F.3d 822, 838 (11th Cir. 1998). "Where invited error exists, it precludes a court from invoking the plain error rule and reversing." United States v. Silvestri, 309 F.3d 1311, 1327 (11th Cir. 2005) (citation omitted).

In this case, not only did Johnston fail to object to the district court's imposition of a national standard of care, but she invited the alleged error by requesting that the court charge the jury that in order to convict they must find that she "acted outside the course/scope of professional practice, not in accordance with a standard of medical practice generally recognized and acted in the United States" (emphasis added). Furthermore, Johnston's proposed jury instructions included charging the jury on the section of the Florida Administrative Code that addresses the state's standards for the use of controlled substances for the treatment of pain, but

Johnston affirmatively withdrew this instruction at the charge conference.[8]

We are also unpersuaded by Johnston's argument that the alleged error in the jury instructions is jurisdictional. "A jurisdictional defect is one that 'strip[s] the court of its power to act and ma[kes] its judgment void.'" McCoy v. United States, 266 F.3d 1245, 1249 (11th Cir. 2001) (citation omitted). An indictment suffers from a jurisdictional defect when it charges no crime at all, i.e. a non-offense. United States v. Peter, 310 F.3d 709, 714-15 (11th Cir. 2002) No such situation exists here because the district court had jurisdiction pursuant to a valid indictment charging Johnston with crimes under the CSA. Because the alleged error is not jurisdictional, we conclude that invited error doctrine precludes review of the jury instruction that applied a national standard of care.

B. Red flags evidence

Johnston argues that the district court erred by permitting the witnesses to testify about "red flag" profiling evidence and that admitting such evidence prejudiced the jury. Johnston alleges that "red flags" is a government-created standard for identifying drug abuse that has not been accepted by the medical community, and therefore is not relevant to the medical standard of care.[9] Additionally,

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[8] At trial, Johnston's attorney also questioned Romano about his opinion as to whether Johnston's treatment "was consistent with accepted professional standards of care in the United States."

[9] Johnston did not raise this argument before the district court and submits it for the first time in her brief. She argues that

Johnston contends that the testimony about red flags was inadmissible under Daubert[10] and the Federal Rules of Evidence because the government failed to establish that the testimony was reliable or relevant. Finally, Johnston argues that the district court improperly permitted experts to use the red flag testimony to reach legal, rather than medical, conclusions.

Johnston did not object to the admissibility of red flag testimony or the experts' conclusions that they reached based on the red flags. Where a party fails to raise an evidentiary objection, we review only for plain error. United States v. Turner, 474 F.3d 1265, 1275 (11th Cir. 2007). To demonstrate plain error, Johnston "must show that: (1) an error occurred; (2) the error was plain; (3) it affected [her] substantial rights; and (4) it seriously affected the fairness of the judicial proceedings." United States v. Gresham, 325 F.3d 1262, 1265 (11th Cir. 2003). An error is not plain unless it is contrary to precedent directly resolving a legal issue. United States v. Lejarde-Rada, 319 F.3d 1288, 1291 (11th Cir. 2003).

We conclude that Johnston has failed to show that the district court committed plain error by admitting the testimony. The Supreme Court has held that an officer does not have reasonable suspicion that someone is engaged in criminal conduct solely on the basis that he fits a profile. Reid

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the term "red flags" originated from a 1999 U.S. Drug Enforcement Administration publication entitled "Don't be Scammed by a Drug Abuser."

[10] Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993) (discussing use of expert testimony that has been determined to be reliable and relevant).

v. Georgia, 448 U.S. 438, 440 (1980) (per curiam) (discussing "the so-called 'drug courier profile'"). This court does not permit the admission of evidence indicating that a defendant fit a particular criminal profile because such evidence is "inherently prejudicial because of the potential [it has] for including innocent citizens." United States v. Hernandez-Cuartas, 717 F.2d 552, 555 (11th Cir. 1983). The instant case, however, is distinguishable. First, the red flag statements were used to create a profile about the patient, not Johnston. These statements were intended to give Johnston reason to believe that Schaible was an addict or was selling his medications. The red flags were introduced to show that Johnston failed to meet the required standard of care in dealing with her patients; not to show that Johnston somehow fit a specific criminal profile. Second, unlike in Reid, Johnston was not identified as a suspect because she fit a certain criminal profile. Instead, she was already a suspect prior to Schaible's red flag statements. There was therefore no danger that an innocent person would be swept up in the investigation simply because she fit a certain profile.

We further conclude that the experts' testimony about the red flags was properly admitted pursuant to Fed. R. Evid. ("Rule") 702. Under Rule 702, "[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert . . . may testify thereto in the form of an opinion or otherwise." Fed. R. Evid. 702. In Daubert, the Supreme Court established a two-part test under Rule 702 for the admissibility of expert testimony: a trial judge must determine

"whether the expert is proposing to testify to (1) scientific knowledge that (2) will assist the trier of fact to understand or determine a fact in issue." 509 U.S. at 592. Some factors that should be considered in exercising this gate-keeping function include "(1) whether the expert's theory can be and has been tested; (2) whether the theory has been subjected to peer review and publication; (3) the known or potential rate of error of the particular scientific technique; and (4) whether the technique is generally accepted in the scientific community." United States v. Douglas, 489 F.3d 1117, 1124-25 (11th Cir. 2007). "The same criteria that are used to assess the reliability of a scientific opinion may be used to evaluate the reliability of non-scientific, experience-based testimony." United States v. Frazier, 387 F.3d 1244, 1262 (11th Cir. 2004) (en banc) (quoting Kumho Tire Co., Ltd. v. Carmichael, 526 U.S. 137, 152 (1999).

Johnston does not challenge the qualifications of the experts, but rather argues that "red flags" are not generally accepted scientific evidence of drugdealing and addiction. We note, however, that neither the government nor witnesses treated "red flags" as a term of art. The witnesses' testimony treated "red flags" as synonymous with "warning signs." The doctors testified that in light of the strange statements made by Johnston's patients, had they confronted similar statements in their own practices, they would have sought further information from the patients before prescribing narcotics. They did not treat "red flags" as a medical standard and therefore Johnston's argument that this evidence is inadmissible under Daubert fails.

We also reject Johnston's argument that the experts improperly testified to legal conclusions. Although experts may not testify to legal conclusions, "testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." Fed. R. Evid. 704(a). Pinsley testified as to the appropriate standard of care in the medical field and gave her opinion that the prescriptions "were written without any legitimate medical purpose." Criminal knowledge and intent are issues of fact, not law. See United States v. Greenfield, 554 F.2d 179, 183 (5th Cir. 1977)[11] ("[D]efendant strenuously asserted that the prescriptions . . . were for a legitimate medical purpose and within the course of his professional practice. Necessarily, the issue of criminal intent or guilty knowledge was a factual issue for the jury to resolve."). Pinsley's testimony was therefore appropriate. In fact, Johnston questioned her own expert about whether he believed Johnston "acted in good faith in prescribing the substances" and "entered into . . . a legitimate therapeutic physician/patient relationship" with each undercover officer.

We therefore conclude that the district court did not plainly err by admitting the red flag evidence and permitting the experts to give opinions based in part on such evidence.

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[11] In Bonner v. City of Prichard, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc), this court held that all decisions handed down by the former Fifth Circuit before the close of business on September 30, 1981, are binding precedent in the Eleventh Circuit.

C. Mens rea

Johnston finally argues that the government did not establish that she acted with bad intent. She contends that the government's only evidence of mens rea came from her failure to react to the detectives' red flags.

We review the denial of a motion for judgment of acquittal based on sufficiency of the evidence de novo, drawing all inferences in the government's favor. United States v. Bowman, 302 F.3d 1228, 1237 (11th Cir. 2002).[12] To convict under 21 U.S.C. § 841, the government must prove that the physician knowingly or intentionally dispensed controlled substances and that she did so other than for a legitimate medical purpose and in the usual course of her professional practice. United States v. Rosen, 582 F.2d 1032, 1033 (5th Cir. 1978). Knowledge can be proven through "inferences based upon surrounding circumstances." United States v. Vera, 701 F.2d 1349, 1358 (11th Cir. 1983); see also United States v. Woodard, 531 F.3d 1352, 1360 (2008) (explaining that the elements can be shown by direct or circumstantial evidence). The credibility of a witness is for the jury to determine. United States v. Parrado, 911 F.2d 1567, 1571 (11th Cir. 1990).

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[12] The government argues that Johnston did not preserve this issue for appeal. We disagree. Johnston moved for a judgment of acquittal at the close of the government's case and at the close of the evidence, arguing that "the evidence is insufficient as a matter of law." Although general motions such as this are typically disfavored, we nonetheless conclude that because intent is an essential element of the crime, the issue of mens rea was adequately preserved for appeal.

We conclude that there was sufficient evidence from which the jury could adduce that Johnston dispensed the medication for reasons other than legitimate medical purposes. The jury heard several suspicious statements that Schaible made to Johnston, including that he was illegally purchasing medication off of friends, that he ran out of medication earlier than he should have, and insinuations that he might also be selling his medication. The jury also heard Baginski's testimony that she believed that Johnston was prompting her with what to say in order to obtain pain medication. The government's experts testified that Johnston's notes were very sparse, that her examinations were unreasonably brief, that she should have physically examined patients, conducted medical tests, and obtained medical records, and that she gave unreasonably strong prescriptions to the patients. Pinsley expressed her opinion that the prescriptions were written outside the scope of medical practice and for no legitimate medical purpose. The jury also heard Johnston's expert's contrary opinion, but was free to choose among reasonable constructions of the evidence. See United States v. Alvarez-Sanchez, 774 F.2d 1036, 1039 (11th Cir. 1985). The district court therefore did not err in denying the motion for a judgment of acquittal.

## III. Conclusion

For the reasons stated, the convictions are hereby affirmed.

**AFFIRMED.**

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

UNITED STATES OF AMERICA

vs. 2:07-cr-105-FtM-29DNF

SHARON JOHNSTON

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**OPINION AND ORDER**

This matter comes before the Court on Defendant's Renewed Motion for Judgment of Acquittal, or in the Alternative, Motion for New Trial (Doc. #76) filed on April 4, 2008. The government filed a Response (Doc. #78) on April 11, 2008.

Defendant renews her motion for judgment of acquittal under FED. R. CRIM. P. 29(c), arguing that there is insufficient evidence to sustain the verdicts. Contrary to defendant's arguments, the Court finds the jury verdicts to be neither capricious or irrational. The Court finds that there was ample evidence from which a reasonable jury could find defendant's guilt beyond a reasonable doubt. Accordingly, defendants Renewed Motion for Judgment of Acquittal is denied.

Defendant requests a new trial pursuant to FED. R. CRIM. P. 33 on the ground that the interest of justice requires a new trial. In deciding a motion for new trial, the trial court is allowed to weigh the evidence and determine credibility for itself. The Court paid close attention to the testimony of all the

witnesses in this interesting case. As in virtually every case, the government's evidence was not without defects and was ably challenged by defense counsel. The Court's evaluation of the weight to be given the various witnesses simply does not coincide with that suggested by defendant. The Court found the witnesses credible, and found the testimony justified the verdicts reached by the jury. While the evidence was disputed, in the Court's view the jury verdicts are fully supported by credible evidence.

The Court also rejects defendant's arguments that it erred in allowing testimony that a search warrant was executed, or in allowing certain cross examination of defendant's expert Dr. Thomas Romano, or in refusing a cautionary instruction concerning certain evidence. The admission of evidence is within the sound discretion of the trial court, and the Court upon reflection finds no evidentiary error.

The Court also finds that the evidence of defendant's guilt is not insufficient as a matter of law, and is not contrary to the greater weight of the evidence. Further, the Court finds that the guilty verdicts are not contrary to the law or the evidence. Finally, the court finds that its jury instructions were proper and adequately covered the pertinent issues.

Accordingly, it is now

**ORDERED:**

Defendant's Renewed Motion for Judgment of Acquittal, or in the Alternative, Motion for New Trial (Doc. #76) is **DENIED**.

**DONE AND ORDERED** at Fort Myers, Florida, this 16th day of April, 2008.

**/s/ John E. Steele**
**JOHN E. STEELE**
**United States District Judge**

Copies:
AUSA Molloy
Counsel of Record

**UNITED STATES DISTRICT COURT**
**MIDDLE DISTRICT OF FLORIDA**
**FT. MYERS DIVISION**

**UNITED STATES OF AMERICA**

**-vs-**

**SHARON JOHNSTON**

**Case Number: 2:07-cr-105-FtM-29DNF**
**USM Number: 34400-018**

Joel Hirschhorn, Retained
Keith Pierro, Retained
550 Biltmore Way

Coral Gables, FL 33134

**JUDGMENT IN A CRIMINAL CASE**

**The defendant was found guilty on Count One, Two, Three & Four of the Indictment. Accordingly, the Court has adjudicated that the defendant is guilty of the following offense(s):**

| Title & Section | Nature of Offense | Date Offense Concluded | Count Number(s) |
|---|---|---|---|
| 21 U.S.C.§§ 841(a)(1), 841(b)(1)(C) | Illegally Dispensing Oxycodone & Alprazolam | June 11, 2007 | One |

| | | | |
|---|---|---|---|
| 21 U.S.C.§§ 841(a)(1), 841(b)(1)(C) | Illegally Dispensing Oxycodone | June 27, 2007 | Two |
| 21 U.S.C.§§ 841(a)(1), 841(b)(1)(C) | Illegally Dispensing Alprazolam & Methadone | July 5, 2007 | Three |
| 21 U.S.C.§§ 841(a)(1), 841(b)(1)(C) | Illegally Dispensing Oxycodone | July 10, 2007 | Four |

The defendant is sentenced as provided in the following pages of this judgment. The sentence is imposed pursuant to the Sentencing Reform Act of 1984, as modified by United States v. Booker, 125 S. Ct. 738 (2005).

**IT IS ORDERED** that the defendant shall notify the United States attorney for this district within 30 days of any change of name, residence, or mailing address until all fines, restitution, costs and special assessments imposed by this judgment are fully paid. If ordered to pay restitution, the defendant shall notify the court and United States attorney of any material change in the defendant's economic circumstances.

Date of Imposition of Sentence:
July 29, 2008
/s/ John E. Steele
**John E. Steele**

United states district judge

July 29, 2008

**IMPRISONMENT**

The defendant is hereby committed to the custody of the United States Bureau of Prisons to be imprisoned for a total term of 30 Months as to each count, to be served concurrently.

**The Court recommends to the Bureau of Prisons:**

**1. Incarceration in a facility close to home (Naples, Florida). The defendant is remanded to the custody of the United States Marshal.**

**RETURN**

I have executed this judgment as follows:

Defendant delivered on_____to
at_____, with a
certified copy of this judgment.

_____
UNITED STATES MARSHAL

By:_____
Deputy U.S. Marshal

## SUPERVISED RELEASE

Upon release from imprisonment, the defendant shall be on supervised release for a term of **Three (3) Years as to each count, to run concurrently.**

The defendant shall report to the probation office in the district to which the defendant is released within 72 hours of release from custody of the Bureau of Prisons.

The defendant shall not commit another federal, state or local crime. The defendant shall not illegally possess a controlled substance. *For offenses committed on or after September 13, 1994*:

The defendant shall refrain from any unlawful use of a controlled substance. The defendant shall submit to one drug test within 15 days of release from imprisonment and at least two periodic drug tests thereafter.

The defendant shall not possess a firearm, destructive device, or any other dangerous weapon.

If this judgment imposes a fine or a restitution obligation, it shall be a condition of supervision that the defendant pay any such fine or restitution that remains unpaid at the commencement of the term of supervision in accordance with the Schedule of Payments set forth

in the Criminal Monetary Penalties sheet of this judgment.

The defendant shall comply with the standard conditions that have been adopted by this court (set forth below). The defendant shall also comply with the additional conditions on the attached page.

## STANDARD CONDITIONS OF SUPERVISION

1. The defendant shall not leave the judicial district without the permission of the court or probation officer;

2. The defendant shall report to the probation officer and shall submit a truthful and complete written report within the first five days of each month;

3. The defendant shall answer truthfully all inquiries by the probation officer and follow the instructions of the probation officer;

4. The defendant shall support his or her dependents and meet other family responsibilities;

5. The defendant shall work regularly at a lawful occupation, unless excused by the probation officer for schooling, training, or other acceptable reasons;

6. The defendant shall notify the probation officer **at least ten (10) days prior** to any change in residence or employment;

7. The defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute, or administer any controlled substance or any paraphernalia related to any controlled substances, except as prescribed by a physician;

8. The defendant shall not frequent places where controlled substances are illegally sold, used, distributed, or administered;

9. The defendant shall not associate with any persons engaged in criminal activity and shall not associate with any person convicted of a felony, unless granted permission to do so by the probation officer;

10. The defendant shall permit a probation officer to visit him or her at any time at home or elsewhere and shall permit confiscation of any contraband observed in plain view by the probation officer;

11. The defendant shall notify the probation officer within **seventy-two (72) hours** of being arrested or questioned by a law enforcement officer;

12. The defendant shall not enter into any agreement to act as an informer or a special agent of a law enforcement agency without the permission of the court;

13. As directed by the probation officer, the defendant shall notify third parties of risks that may be occasioned by the defendant's criminal record or personal history or characteristics, and shall permit the probation officer to make such notifications and

to confirm the defendant's compliance with such notification requirement.

## ADDITIONAL CONDITIONS OF SUPERVISED RELEASE

The defendant shall also comply with the following additional conditions of supervised release:

1. The defendant shall participate as directed in a substance abuse program (outpatient and/or inpatient) and follow the Probation Officer's instructions regarding the implementation of this Court directive. Further, the defendant shall be required to contribute to the costs of services not to exceed an amount determined reasonable by the Probation Office's Sliding Scale for Substance Abuse Treatment Services. During and upon the completion of this program, the defendant is directed to submit to random drug testing.

2. The defendant shall participate in a mental health treatment program (outpatient and/or inpatient) and shall follow the probation officer's instructions regarding the implementation of this court directive. Further, the defendant shall be required to contribute to the costs of these services not to exceed an amount determined reasonable by the Probation Office's Sliding Scale for Mental Health Treatment Services.

3. Having been convicted of a qualifying felony offense, the defendant shall cooperate with the

probation office in the collection of DNA, if not already collected by the Bureau of Prisons.

4. The mandatory drug testing requirements of the Violent Crime Control Act are imposed. The Court orders the defendant to submit to random drug testing not to exceed 104 tests per year.AO 245B (Rev. 3/01) Judgment in a Criminal Case

## CRIMINAL MONETARY PENALTIES

The defendant shall pay the following total criminal monetary penalties in accordance with the schedule of payments set forth in the Schedule of Payments.

| Total Assessment | Total Fine | Total Restitution |
|---|---|---|
| $400.00 (Due Immediately) | Waived | N/A |

The defendant shall pay interest on any fine or restitution of more than $2,500, unless the fine or restitution is paid in full before the fifteenth day after the date of the judgment, pursuant to 18 U.S.C. § 3612(f). All of the payment options on the Schedule of Payments may be subject to penalties for delinquency and default, pursuant to 18 U.S.C. § 3612(g).

The mandatory drug testing requirements of the Violent Crime Control Act are imposed. Based on the Court's determination that additional drug

urinalysis is necessary, the Court authorizes random drug testing not to exceed 104 tests per year.

*Findings for the total amount of losses are required under Chapters 109A, 110, 110A, and 113A of Title 18, United States Code, for offenses committed on or after September 13, 1994 but before April 23, 1996.

Amendment X. Reserved Powers

## AMENDMENTS - BILL OF RIGHTS

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

**21 USC § 802**
**Title 21 - FOOD AND DRUGS**
**Chapter 13 - DRUG ABUSE PREVENTION AND CONTROL**

As used in this subchapter:

(1) The term "addict" means any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction.

(2) The term "administer" refers to the direct application of a controlled substance to the body of a patient or research subject by -

(A) a practitioner (or, in his presence, by his authorized agent), or

(B) the patient or research subject at the direction and in the presence of the practitioner,

whether such application be by injection, inhalation, ingestion, or any other means.

(3) The term "agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser; except that such term does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman, when acting in the usual and lawful course of the carrier's or warehouseman's business.

(4) The term "Drug Enforcement Administration" means the Drug Enforcement Administration in the Department of Justice.

(5) The term "control" means to add a drug or other substance, or immediate precursor, to a schedule under part B of this subchapter, whether by transfer from another schedule or otherwise.

(6) The term "controlled substance" means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V of part B of this subchapter. The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986.

(7) The term "counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person or persons who in fact manufactured, distributed, or dispensed such substance and which thereby falsely purports or is represented to be the product of, or to have been distributed by, such other manufacturer, distributor, or dispenser.

(8) The terms "deliver" or "delivery" mean the actual, constructive, or attempted transfer of a controlled substance or a listed chemical, whether or not there exists an agency relationship.

(9) The term "depressant or stimulant substance" means -

(A) a drug which contains any quantity of barbituric acid or any of the salts of barbituric acid; or

(B) a drug which contains any quantity of (i) amphetamine or any of its optical isomers; (ii) any salt of amphetamine or any salt of an optical isomer of amphetamine; or (iii) any substance which the Attorney General, after investigation, has found to be, and by regulation designated as, habit forming because of its stimulant effect on the central nervous system; or

(C) lysergic acid diethylamide; or

(D) any drug which contains any quantity of a substance which the Attorney General, after investigation, has found to have, and by regulation designated as having, a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect.

(10) The term "dispense" means to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term "dispenser" means a practitioner who so delivers a controlled substance to an ultimate user or research subject.

(11) The term "distribute" means to deliver (other than by administering or dispensing) a controlled substance or a listed chemical. The term

"distributor" means a person who so delivers a controlled substance or a listed chemical.

(12) The term "drug" has the meaning given that term by section 321(g)(1) of this title.

(13) The term "felony" means any Federal or State offense classified by applicable Federal or State law as a felony.

(14) The term "isomer" means the optical isomer, except as used in schedule I(c) and schedule II(a)(4). As used in schedule I(c), the term "isomer" means any optical, positional, or geometric isomer. As used in schedule II(a)(4), the term "isomer" means any optical or geometric isomer.

(15) The term "manufacture" means the production, preparation, propagation, compounding, or processing of a drug or other substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of such substance or labeling or relabeling of its container; except that such term does not include the preparation, compounding, packaging, or labeling of a drug or other substance in conformity with applicable State or local law by a practitioner as an incident to his administration or dispensing of such drug or substance in the course of his professional practice. The term "manufacturer" means a person who manufactures a drug or other substance.

(16) The term "marihuana" means all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. Such term does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

(17) The term "narcotic drug" means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(A) Opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation. Such term does not include the isoquinoline alkaloids of opium.

(B) Poppy straw and concentrate of poppy straw.

(C) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed.

(D) Cocaine, its salts, optical and geometric isomers, and salts of isomers.

(E) Ecgonine, its derivatives, their salts, isomers, and salts of isomers.

(F) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subparagraphs (A) through (E).

(18) The term "opiate" means any drug or other substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

(19) The term "opium poppy" means the plant of the species Papaver somniferum L., except the seed thereof.

(20) The term "poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(21) The term "practitioner" means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

(22) The term "production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance.

(23) The term "immediate precursor" means a substance -

(A) which the Attorney General has found to be and by regulation designated as being the principal compound used, or produced primarily for use, in the manufacture of a controlled substance;

(B) which is an immediate chemical intermediary used or likely to be used in the manufacture of such controlled substance; and

(C) the control of which is necessary to prevent, curtail, or limit the manufacture of such controlled substance.

(24) The term "Secretary", unless the context otherwise indicates, means the Secretary of Health and Human Services.

(25) The term "serious bodily injury" means bodily injury which involves -

(A) a substantial risk of death;

(B) protracted and obvious disfigurement; or

(C) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

(26) The term "State" means a State of the United States, the District of Columbia, and any commonwealth, territory, or possession of the United States.

**21 USC § 829**
**Title 21 - FOOD AND DRUGS**
**Chapter 13 - DRUG ABUSE PREVENTION AND CONTROL**

SUBCHAPTER I - CONTROL AND ENFORCEMENT

Part C - Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances

(a) Schedule II substances

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule II, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], may be dispensed without the written prescription of a practitioner, except that in emergency situations, as prescribed by the Secretary by regulation after consultation with the Attorney General, such drug may be dispensed upon oral prescription in accordance with section 503(b) of that Act [21 U.S.C. 353(b)]. Prescriptions shall be retained in conformity with the requirements of section 827 of this title. No prescription for a controlled substance in schedule II may be refilled.

(b) Schedule III and IV substances

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule III or IV, which is a prescription drug as determined under

the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], may be dispensed without a written or oral prescription in conformity with section 503(b) of that Act [21 U.S.C. 353(b)]. Such prescriptions may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription unless renewed by the practitioner.

(c) Schedule V substances

No controlled substance in schedule V which is a drug may be distributed or dispensed other than for a medical purpose.

(d) Non-prescription drugs with abuse potential

Whenever it appears to the Attorney General that a drug not considered to be a prescription drug under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] should be so considered because of its abuse potential, he shall so advise the Secretary and furnish to him all available data relevant thereto.

(Pub. L. 91-513, title II, Sec. 309, Oct. 27, 1970, 84 Stat. 1260.)

**21 USC § 841**
**Title 21 - FOOD AND DRUGS**
**Chapter 13 - DRUG ABUSE PREVENTION AND CONTROL**

(a) Unlawful acts

Except as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally -

(1) to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance; or

(2) to create, distribute, or dispense, or possess with intent to distribute or dispense, a counterfeit substance.

(b) Penalties

Except as otherwise provided in section 849, 859, 860, or 861 of this title, any person who violates subsection (a) of this section shall be sentenced as follows:

(1)(A) In the case of a violation of subsection (a) of this section involving -

(i) 1 kilogram or more of a mixture or substance containing a detectable amount of heroin;

(ii) 5 kilograms or more of a mixture or substance containing a detectable amount of -

(I) coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and

derivatives of ecgonine or their salts have been removed;

(II) cocaine, its salts, optical and geometric isomers, and salts of isomers;

(III) ecgonine, its derivatives, their salts, isomers, and salts of isomers; or

(IV) any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subclauses (I) through (III);

(iii) 50 grams or more of a mixture or substance described in clause (ii) which contains cocaine base;

(iv) 100 grams or more of phencyclidine (PCP) or 1 kilogram or more of a mixture or substance containing a detectable amount of phencyclidine (PCP);

(v) 10 grams or more of a mixture or substance containing a detectable amount of lysergic acid diethylamide (LSD);

(vi) 400 grams or more of a mixture or substance containing a detectable amount of N-phenyl-N-[ 1-(2-phenylethyl ) -4-piperidinyl ] propanamide or 100 grams or more of a mixture or substance containing a detectable amount of any analogue of N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl] propanamide;

(vii) 1000 kilograms or more of a mixture or substance containing a detectable amount of

marihuana, or 1,000 or more marihuana plants regardless of weight; or

(viii) 50 grams or more of methamphetamine, its salts, isomers, and salts of its isomers or 500 grams or more of a mixture or substance containing a detectable amount of methamphetamine, its salts, isomers, or salts of its isomers;

such person shall be sentenced to a term of imprisonment which may not be less than 10 years or more than life and if death or serious bodily injury results from the use of such substance shall be not less than 20 years or more than life, a fine not to exceed the greater of that authorized in accordance with the provisions of title 18 or $4,000,000 if the defendant is an individual or $10,000,000 if the defendant is other than an individual, or both. If any person commits such a violation after a prior conviction for a felony drug offense has become final, such person shall be sentenced to a term of imprisonment which may not be less than 20 years and not more than life imprisonment and if death or serious bodily injury results from the use of such substance shall be sentenced to life imprisonment, a fine not to exceed the greater of twice that authorized in accordance with the provisions of title 18 or $8,000,000 if the defendant is an individual or $20,000,000 if the defendant is other than an individual, or both. If any person commits a violation of this subparagraph or of section 849, 859, 860, or 861 of this title after two or more prior convictions for a felony drug offense have become final, such person shall be sentenced to a mandatory term of life imprisonment without release and fined in accordance with the preceding sentence.

Notwithstanding section 3583 of title 18, any sentence under this subparagraph shall, in the absence of such a prior conviction, impose a term of supervised release of at least 5 years in addition to such term of imprisonment and shall, if there was such a prior conviction, impose a term of supervised release of at least 10 years in addition to such term of imprisonment. Notwithstanding any other provision of law, the court shall not place on probation or suspend the sentence of any person sentenced under this subparagraph. No person sentenced under this subparagraph shall be eligible for parole during the term of imprisonment imposed therein.

**21 USC § 843**
**Title 21 - FOOD AND DRUGS**
**Chapter 13 - DRUG ABUSE PREVENTION AND CONTROL**

SUBCHAPTER I - CONTROL AND ENFORCEMENT

Part D - Offenses and Penalties

(a) Unlawful acts

It shall be unlawful for any person knowingly or intentionally -

(1) who is a registrant to distribute a controlled substance classified in schedule I or II, in the course of his legitimate business, except pursuant to an order or an order form as required by section 828 of this title;

(2) to use in the course of the manufacture, distribution, or dispensing of a controlled substance, or to use for the purpose of acquiring or obtaining a controlled substance, a registration number which is fictitious, revoked, suspended, expired, or issued to another person;

(3) to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge;

(4)(A) to furnish false or fraudulent material information in, or omit any material information from, any application, report, record, or other document required to be made, kept, or filed under this subchapter or subchapter II of this chapter, or

(B) to present false or fraudulent identification where the person is receiving or purchasing a listed chemical and the person is required to present identification under section 830(a) of this title;

(5) to make, distribute, or possess any punch, die, plate, stone, or other thing designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any of the foregoing upon any drug or container or labeling thereof so as to render such drug a counterfeit substance;

(6) to possess any three-neck round-bottom flask, tableting machine, encapsulating machine, or gelatin capsule, or any equipment, chemical, product, or material which may be used to manufacture a controlled substance or listed chemical, knowing, intending, or having reasonable cause to believe, that it will be used to manufacture a controlled substance or listed chemical in violation of this subchapter or subchapter II of this chapter;

(7) to manufacture, distribute, export, or import any three-neck round-bottom flask, tableting machine, encapsulating machine, or gelatin capsule, or any equipment, chemical, product, or material which may be used to manufacture a controlled substance or listed chemical, knowing, intending, or having reasonable cause to believe, that it will be used to manufacture a controlled substance or listed chemical in violation of this subchapter or subchapter II of this chapter or, in the case of an exportation, in violation of this subchapter or subchapter II of this chapter or of the laws of the country to which it is exported;

(8) to create a chemical mixture for the purpose of evading a requirement of section 830 of this title or to receive a chemical mixture created for that purpose; or

(9) to distribute, import, or export a list I chemical without the registration required by this subchapter or subchapter II of this chapter.

(b) Communication facility

It shall be unlawful for any person knowingly or intentionally to use any communication facility in committing or in causing or facilitating the commission of any act or acts constituting a felony under any provision of this subchapter or subchapter II of this chapter. Each separate use of a communication facility shall be a separate offense under this subsection. For purposes of this subsection, the term "communication facility" means any and all public and private instrumentalities used or useful in the transmission of writing, signs, signals, pictures, or sounds of all kinds and includes mail, telephone, wire, radio, and all other means of communication.

(c) Advertisement

It shall be unlawful for any person to place in any newspaper, magazine, handbill, or other publications, any written advertisement knowing that it has the purpose of seeking or offering illegally to receive, buy, or distribute a Schedule I controlled substance. As used in this section the term "advertisement" includes, in addition to its ordinary meaning, such advertisements as those for a catalog

of Schedule I controlled substances and any similar written advertisement that has the purpose of seeking or offering illegally to receive, buy, or distribute a Schedule I controlled substance. The term "advertisement" does not include material which merely advocates the use of a similar material, which advocates a position or practice, and does not attempt to propose or facilitate an actual transaction in a Schedule I controlled substance.

(d) Penalties

(1) Except as provided in paragraph (2), any person who violates this section shall be sentenced to a term of imprisonment of not more than 4 years, a fine under title 18, or both; except that if any person commits such a violation after one or more prior convictions of him for violation of this section, or for a felony under any other provision of this subchapter or subchapter II of this chapter or other law of the United States relating to narcotic drugs, marihuana, or depressant or stimulant substances, have become final, such person shall be sentenced to a term of imprisonment of not more than 8 years, a fine under title 18, or both.

(2) Any person who, with the intent to manufacture or to facilitate the manufacture of methamphetamine, violates paragraph (6) or (7) of subsection (a) of this section, shall be sentenced to a term of imprisonment of not more than 10 years, a fine under title 18, or both; except that if any person commits such a violation after one or more prior convictions of that person -

(A) for a violation of paragraph (6) or (7) of subsection (a) of this section;

(B) for a felony under any other provision of this subchapter or subchapter II of this chapter; or

(C) under any other law of the United States or any State relating to controlled substances or listed chemicals,

has become final, such person shall be sentenced to a term of imprisonment of not more than 20 years, a fine under title 18, or both.

(e) Additional penalties

In addition to any other applicable penalty, any person convicted of a felony violation of this section relating to the receipt, distribution, manufacture, exportation, or importation of a listed chemical may be enjoined from engaging in any transaction involving a listed chemical for not more than ten years.

(f) Injunctions

(1) In addition to any penalty provided in this section, the Attorney General is authorized to commence a civil action for appropriate declaratory or injunctive relief relating to violations of this section, section 842 of this title, or 856 of this title.

(2) Any action under this subsection may be brought in the district court of the United States for the district in which the defendant is located or resides or is doing business.

(3) Any order or judgment issued by the court pursuant to this subsection shall be tailored to restrain violations of this section or section 842 of this title.

(4) The court shall proceed as soon as practicable to the hearing and determination of such an action. An action under this subsection is governed by the Federal Rules of Civil Procedure except that, if an indictment has been returned against the respondent, discovery is governed by the Federal Rules of Criminal Procedure.

(Pub. L. 91-513, title II, Sec. 403, Oct. 27, 1970, 84 Stat. 1263; Pub. L. 95-633, title II, Sec. 202(b)(3), Nov. 10, 1978, 92 Stat. 3776; Pub. L. 98-473, title II, Sec. 516, Oct. 12, 1984, 98 Stat. 2074; Pub. L. 99-570, title I, Sec. 1866(a), Oct. 27, 1986, 100 Stat. 3207-54; Pub. L. 100-690, title VI, Sec. 6057, Nov. 18, 1988, 102 Stat. 4319; Pub. L. 103-200, Sec. 3(g), Dec. 17, 1993, 107 Stat. 2337; Pub. L. 103-322, title IX, Sec. 90106, Sept. 13, 1994, 108 Stat. 1988; Pub. L. 104-237, title II, Secs. 203(a), 206(b), Oct. 3, 1996, 110 Stat. 3102, 3103; Pub. L. 107-273, div. B, title IV, Sec. 4002(d)(2)(C), Nov. 2, 2002, 116 Stat. 1810; Pub. L. 108-21, title VI, Sec. 608(d), Apr. 30, 2003, 117 Stat. 691.)

**21 USC § 903**
**Title 21 - FOOD AND DRUGS**
**Chapter 13 - DRUG ABUSE PREVENTION AND CONTROL**

SUBCHAPTER I - CONTROL AND ENFORCEMENT

Part F - General Provisions

No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.

(Pub. L. 91-513, title II, Sec. 708, Oct. 27, 1970, 84 Stat. 1284.)

**381.026 Florida Patient's Bill of Rights and Responsibilities.--**

(1) SHORT TITLE.--This section may be cited as the "Florida Patient's Bill of Rights and Responsibilities."

(2) DEFINITIONS.--As used in this section and s. 381.0261, the term:

(a) "Department" means the Department of Health.

(b) "Health care facility" means a facility licensed under chapter 395.

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.

(d) "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.

(3) PURPOSE.--It is the purpose of this section to promote the interests and well-being of the patients of health care providers and health care facilities and to promote better communication between the patient and the health care provider. It is the intent of the Legislature that health care providers understand their responsibility to give their patients a general understanding of the procedures to be performed on them and to provide information

pertaining to their health care so that they may make decisions in an informed manner after considering the information relating to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. It is the intent of the Legislature that patients have a general understanding of their responsibilities toward health care providers and health care facilities. It is the intent of the Legislature that the provision of such information to a patient eliminate potential misunderstandings between patients and health care providers. It is a public policy of the state that the interests of patients be recognized in a patient's bill of rights and responsibilities and that a health care facility or health care provider may not require a patient to waive his or her rights as a condition of treatment. This section shall not be used for any purpose in any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law.

(4) RIGHTS OF PATIENTS.--Each health care facility or provider shall observe the following standards:

(a) *Individual dignity.*--

1. The individual dignity of a patient must be respected at all times and upon all occasions.

2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's

economic status or source of payment for his or her care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office. However, this subparagraph does not preclude necessary and discreet discussion of a patient's case or examination by appropriate medical personnel.

3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment.

4. A patient in a health care facility has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or

programmatically contraindicated for documented medical, safety, or programmatic reasons.

(b) *Information.--*

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

(c) *Financial information and disclosure.*--

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary

counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A health care provider or a health care facility shall, upon request, furnish a person, prior to provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, prior to the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Estimates shall, to the extent possible, be written in a language comprehensible to an ordinary layperson. Such reasonable estimate shall not preclude the health care

provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

4. Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a description of and a link to the performance outcome and financial data that is published by the agency pursuant to s. 408.05(3)(k). The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

5. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

(d) *Access to health care.*--

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

(e) *Experimental research.*--In addition to the provisions of s. 766.103, a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

(f) *Patient's knowledge of rights and responsibilities.*--In receiving health care,

patients have the right to know what their rights and responsibilities are.

(5) RESPONSIBILITIES OF PATIENTS.--Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients which, considering the nature of their illness, is reasonable and responsible. Each patient shall observe the responsibilities described in the following summary.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment,

whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations,

medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

**21 CFR 1306.04 Purpose of issue of prescription.**

**TITLE 21–FOOD AND DRUGS**

**PART 1306–PRESCRIPTIONS**

CHAPTER II -- DRUG ENFORCEMENT ADMINISTRATION, DEPARTMENT OF JUSTICE

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

(b) A prescription may not be issued in order for an individual practitioner to obtain controlled substances for supplying the individual practitioner for the purpose of general dispensing to patients.

(c) A prescription may not be issued for "detoxification treatment" or "maintenance treatment," unless the prescription is for a Schedule III, IV, or V narcotic drug approved by the Food and

Drug Administration specifically for use in maintenance or detoxification treatment and the practitioner is in compliance with requirements in § 1301.28 of this chapter.

[36 FR 7799, Apr. 24, 1971. Redesignated at 38 FR 26609, Sept. 24, 1973, and amended at 39 FR 37986, Oct. 25, 1974; 70 FR 36343, June 23, 2005]

IN THE
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

APPEAL NO. 08-14594-HH
DISTRICT COURT NO. 2:07-CR-105-FTM-29DNF

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

vs.

SHARON JOHNSTON,
Defendant-Appellant.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

# BRIEF OF UNITED STATES OF AMERICA
CRIMINAL CASE

A. BRIAN ALBRITTON
United States Attorney

DAVID P. RHODES
Assistant United States Attorney
Chief, Appellate Division

By:
LINDA JULIN MCNAMARA
Assistant United States Attorney
Deputy Chief, Appellate Division
Florida Bar No. 714887
400 North Tampa Street, Suite 3200
Tampa, Florida 33602
Telephone: (813) 274-6306
Facsimile: (813) 274-6102

DATE: December 4,2008

* * *

## ARGUMENT AND CITATIONS OF AUTHORITY

### I. JOHNSTON INVITED THE DISTRICT COURT TO INSTRUCT THE JURY TO EVALUATE JOHNSTON'S CONDUCT PURSUANT TO NATIONAL STANDARDS.

Raising the issue for the first time, Johnston contends that the district court should have required the United States to "prove its case in accordance with the controlling State authority" and should have instructed the jury that Florida law controlled. Johnston's brief at 17. Because Johnston invited the district court to instruct the jury to evaluate Johnston's professional behavior pursuant to the standard of care generally accepted in the United States and never requested the district court to instruct the jury on Florida law, Johnston is not entitled to appellate review of this issue.

As Johnston explains in her brief, she was charged with four counts of knowingly and willfully acting outside the scope of professional practice by dispensing controlled substances, in violation of 21 U.S.C. § 841(a)(1) and (b)(1)(C). Doc. 9. Regarding "the scope ofprofessional practice," the district court instructed the jury, in part:

> To determine the usual course of medical practice, you may consider the totality of the circumstances, including evidence of accepted professional standards of care and expert testimony.
>
> . . . .

> Objectively honest efforts to prescribe controlled substances in compliance with the accepted standard of medical-professional medical practice is not criminal. On the other hand, a physician's mere subjective personal belief that she is meeting a person's medical needs by prescribing a controlled substance is not sufficient to show good faith if the physician acts outside the accepted standard of medical practice in the United States.

Doc. 91 at 875-76.

In her brief, Johnston contends that this instruction constituted error because the individual states retain authority to regulate the practice of medicine. Doc. 91 at 22-32. Johnston, however, never asserted this argument in the district court and never challenged the district court's draft instruction that referred to the "standard of medical practice generally recognized and accepted in the United States." Doc. 60 at 14. More importantly, Johnston invited the district court in her own draft jury instructions to instruct the jury to evaluate Johnston's conduct pursuant to a "standard of medical practice generally recognized and acted in the United States."[1] See Doc. 49 at 6-7; see also Doc.

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[1] Johnston also requested the district court to take judicial notice of the section of the Florida Administrative Code that addresses the use of controlled substances for the treatment of pain, Doc. 45, and the district court granted that request, without opposition, Doc. 46. During the trial, Johnston published that section to the jury. Doc. 90 at 628. She later

90 at 739-97 (charge conference); United States v. Silvestri, 409 F.3d 1311, 1327-28 (11th Cir. 2005) (The doctrine of invited error is implicated when a party induces or invites the district court into making an error, and "[w]here invited error exists, it precludes a court from invoking the plain error rule and reversing."). She argued the "national standard" extensively to the jury. Doc. Doc. 91 at 836-37; accord Doc. 91 at 839,844-45. Describing the standard to the jury, Johnston's counsel explained that a controlled substance is lawfully prescribed if, among other things, it "is prescribed by the physician in good faith as part of the physician's medical treatment of the patient in accordance with the standard of medical practice generally recognized and accepted in the United States. Not over on the east coast, Daytona or Boynton Beach, whatever-wherever [the United States' expert] is." Doc. 91 at 845.

This Court has found invited error not subject to review in circumstances similar to this case, in which a defendant indicated in the district court that a jury instruction was acceptable but then attempted to challenge that instruction on appeal. See United States v. Fulford, 267 F.3d 1241, 1247 (11th Cir. 2001) ("It is 'a cardinal rule of appellate review that a party may not challenge as error a ruling or other trial proceeding invited by that party.'"). This Court in Fulford refused to address the defendant's challenge to the jury instruction on appeal, and this Court should do the same in this case. Johnston should not be allowed to ask the district court to

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withdrew her request for the court to instruct the jury on that provision. Doc. 90 at 795.

instruct the jury this way, agree to the district court's instructing the jury this way, and then ask this Court to grant her a new trial because the district court instructed the jury this way.

If this Court determines that review of this issue is appropriate, review should be only for plain error. United States v. Merrill, 513 F.3d 1293, 1305 (11th Cir. 2008). Under the plain error standard, this Court will reverse based on a challenge to a jury instruction that the defendant did not assert at trial only if the instructions were "so clearly erroneous as to result in a likelihood of a grave miscarriage of justice or ... seriously affect[ ] the fairness, integrity or public reputation of [the] judicial proceeding." United States v. Williams, 527 F.3d 1235, 1246 (11th Cir. 2008).

Johnston has not shown that the district court plainly erred because this Court has approved the use of a jury instruction that measures a physician-defendant's conduct against "a standard of medical practice generally recognized and accepted in the United States." See Merrill, 513 F.3d at 1306 (the appropriate focus is not on the subjective intent of the doctor, but rather it rests upon whether the physician prescribes medicine "in accordance with a standard of medical practice generally recognized and accepted in the United States"); United States v. Williams, 445 F.3d 1302, 1309 (11th Cir. 2006) (approving instruction that said, "A controlled substance is prescribed by a physician in the usual course of a professional practice and, therefore, lawfully, if the substance is prescribed by him in good faith as part of his medical treatment of a patient in accordance with the standard of medical

practice generally recognized and accepted in the United States"); accord United States v. Hayes, 794 F.2d 1348, 1351-52 (9th Cir. 1986) (finding no error in charge that required jury to determine that physician acted other than in good faith and defined good faith as "an honest effort to prescribe for a patient's condition in accordance with the standard of medical practice generally recognized and accepted in the country"); United States v. Norris, 780 F.2d 1207, 1209 n.2 (5th Cir. 1986) (finding proper district court's instruction that "[a] controlled substance is prescribed by a physician in the usual course of a professional practice, and, therefore, lawfully, if the substance is prescribed by him in good faith, medically treating a patient in accordance with a standard of .medical practice generally recognized and accepted in the United States"). Furthermore, although the United States Supreme Court did not squarely address the issue in United States v. Moore, 423 U.S. 122, 96 S. Ct. 335 (1975), the district court in Moore had instructed the jury that, to find the defendant guilty, it had to find

> beyond a reasonable doubt that a physician, who knowingly or intentionally, did dispense or distribute methadone by prescription, did so other than in good faith for detoxification in the usual course of a professional practice and in accordance with a standard of medical practice generally recognized and accepted in the United States.

423 U.S. at 138, 96 S. Ct. 343 (emphasis added). The Moore Court did not question the accuracy of this

instruction when addressing the sufficiency of the evidence on the question of whether the defendant had "exceeded the bounds of professional practice." See 423 U.S. at 142-43, 96 S. Ct. at 345-46. Many courts, including this Court, have interpreted Moore as implicitly approving this instruction. See, e.g., United States v. Feingold, 454 F.3d 1001, 1009 (9th Cir.), cert. denied, 127 S. Ct. 695 (2006); Williams, 445 F.3d at 1309; United States v. Vamos, 797 F.2d 1146, 1151 (2d Cir. 1986); United States v. Norris, 780 F.2d 1207, 1209 (5th Cir. 1986). Under these circumstances, the district court could not have plainly erred by instructing the jury similarly to the instruction Moore approved.

In any event, Johnston's premise that the conduct of a physician charged pursuant to section 841(a)(l) cannot be measured pursuant to a national standard simply because the states regulate physicians for many purposes is entirely faulty. Johnston's argument relies on Gonzalez v. Oregon, 546 U.S. 243, 126 S. Ct. 904 (2006), in which the Supreme Court considered the validity of an interpretive rule the Attorney General had issued pursuant to regulation, determining that the use of controlled substances to assist suicide does not constitute a legitimate medical practice and that dispensing or prescribing controlled substances for this purpose violates the Controlled Substances Act (the "CSA"). The case arose when the State of Oregon, which had enacted a statutory scheme permitting such prescriptions under certain circumstances, and others, sued to enjoin enforcement of this rule. The Gonzalez Court ruled that the Attorney General's interpretation of the provisions of the CSA requiring that all prescriptions

be issued "for accepted medical use" and "in the course of professional practice" was not entitled to deference, concluding that "the CSA's prescription requirement does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct." 546 U.S. at 257, 26 S. Ct. at 925. The Court stated that, because the applicable federal regulation, 21 C.F.R. § 1306.04, did not indicate how to decide whether a particular activity was in the "course of professional practice," the Attorney General's rule could not be considered a legitimate interpretation of the regulation. 546 U.S. at 257, 126 S. Ct. at 915.

The Court ruled further that, although the Attorney General has rulemaking power to fulfill his duties under the CSA, he may not "make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law." 546 U.S. at258, 126 S. Ct. at 916. His rulemaking power extends only to the scheduling of controlled substances and the registering of physicians to dispense controlled substances. 546 U.S at 259-61, 126 S. Ct. at 917-18.

Gonzalez does not apply to this case, because Johnston's prosecution pursuant to section 841 implicates no particular state law, and no applicable federal law or regulation purports to trump applicable state law. Although, as Johnston notes in her brief at page 23, Florida has various statutes relating to the administration of controlled substances for pain regulation, those statutes do not specify any particular actions a physician must take in the evaluation and diagnosis of a patient before

the substances may be administered. Fla. Stat. § 458.326 merely requires physicians generally to exercise "the level of care, skill, and treatment recognized by a reasonably prudent physician under similar conditions and circumstances," a requirement that is entirely consistent with the standard that Moore approved. Johnston has not shown how instructing the jury to evaluate the physician's conduct to see Whether it fell "outside the accepted standard of medical practice in the United States" offends any of the Florida statutes that she cites in her brief. Accordingly, Johnston cannot demonstrate harm to her substantial rights. See Watson v. United States, 485 F.3d 1100, 1106 n.3 (10th Cir. 2007) (defendant suffered no harm to her substantial rights due to expert witness's testimony that he did not know the national standard of care where he testified about the relevant community standards of care and the parties had not identified any difference in the two standards).

Furthermore, none of the Florida cases that Johnston cites in her brief at pages 25-26 are instructive in this case, because those cases did not arise in the Same context as this case. Forlaw v. Fitzer, 456 So. 2d 432, 434-36 (Fla. 1984), is a civil, medical malpractice case, addressing the standard for establishing civil liability resulting from the prescription of controlled substances. Hoover v. Agency for Health Care Admin., 676 So.2d 1380, 1382 (Fla. Dist. Ct. App. 1996), and Johnston v. Dep't of Prof. Reg., Bd. of Medical Examiners, 456 So.2d 939 (Fla. Dist. Ct. App. 1984), both involved review of the sufficiency of the evidence in a Florida Board of Medicine disciplinary proceeding. Those courts' rulings interpreting the Florida statutes

applicable under the circumstances in those cases do not apply to a criminal prosecution pursuant to federal law, nor do they even conflict with the jury instruction that the district court issued in this case.[2]

Apparently aware that she failed to raise this issue in the district court, Johnston asserts in a footnote that the district court's failure to require the United States "to prove its case in accordance with the controlling law of the State of Florida" and its alleged error in instructing the jury to consider a "national standard of care" constitutes a "jurisdictional defect" that cannot be waived. Johnston's brief at 27, n.21. As the Court explained in McCoy v. United States, 266 F.3d 1245, 1249 (11th Cir. 2001), however, "A jurisdictional defect is one that 'strip[s] the court of its power to act and ma[kes] its judgment void.'" The district court's failure to instruct the jury on a particular standard of care in this case or to hold the United States to a particular burden of proof, even if that failure had been erroneous, did not "strip the court of its power to act" in this case, where the grand jury returned a valid indictment charging Johnston with federal crimes.

Next, Johnston contends that, even if she cannot prevail on her waiver argument, she still is entitled to relief from her convictions because the

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[2] Although evidence that a physician repeatedly had failed to meet the civil standard of care might be relevant circumstantial evidence tending to show that the physician had acted outside the course of professional practice, see United States v. Williams, 445 F.3d 1302, 1308 (11th Cir. 2006), the state courts' failure to find civil liability under circumstances dissimilar to this case is not instructive here.

United States failed to present sufficient evidence of the appropriate standard of care by which the jury was supposed to evaluate her conduct. Johnston's brief at 27-28. The record, however, shows that, when asked about whether it would be "medically appropriate, or legitimate, for, one day, a doctor to prescribe a patient 15 milligrams of Roxicodone, to be taken five times a day, and, less than four weeks later, increase that same patient's medication to 40 milligrams of Methadone, to be taken five times a day," Doc. 89 at 486-87, the expert testified that "that is a rapid increase in pain medication which would put the patient at risk for a severe side effect, such as an overdose, coma, or even respiratory depression, and even death," Doc. 89 at 487-88.

A second pain management expert testified regarding the types of examinations that an osteopath normally conducts when a patient complains of pain. Doc. 89 at 528-38. She testified that she had reviewed Johnston's patient files to see whether Johnston was acting within the standard of care for her profession. Doc. 89 at 547-48,550. She testified that she also had reviewed the reports of the visits of the three undercover officers and the transcripts of the secretly taped conversations between Johnston and two of the officers. Doc. 89 at 551. She testified that, although she regularly reviews patient files as part of a peer review system to see whether doctors are practicing within the standard of care for the profession, Johnston's patient files were the most sparse she ever had reviewed. Doc. 89 at 547-50. She testified that Johnston's prescription of Roxicodone and Xanax to one of the agents on his first visit to Johnston had not been appropriate and that other diagnostic tests

should have been performed. Doc. 89 at 552. She also testified that the patient records of "Marcus Damm" indicated no justification for the increase in medication from 15 milligrams of Roxicodone to 40 milligrams of Methadone. Doc. 89 at 553. The expert testified further that Johnston's prescription of Roxicodone to "Amber Needles" and of Roxicodone, Neurontin, and Flexeril to "Don Neiczticz" on their first visits to her also had been inappropriate. Doc. 89 at 554-56. Asked generally whether, after reviewing the transcripts and the pertinent patient files in this case, appropriate treatment and diagnosis had been done in this case regarding the Undercover agents, the expert testified, "I do not." Doc. 89 at 556. She testified that the physical exam was lacking in detail, that the treatment was inaccurate, that stronger medications had been prescribed than were appropriate, that prescriptions had been written outside the scope of professional practice, and that the prescriptions had been written without any legitimate medical purpose. Doc. 89 at 556-57.

The district court instructed the jury, without objection from Johnston, that, "To determine the usual course of medical practice, you may consider the totality of the circumstances, including evidence of accepted professional standards of care and expert testimony." Doc. 91 at 875. The testimony of these experts regarding their own particular practices in the context of their testimony for their reasons for these practices, in addition to their testimony regarding the types of examinations that osteopaths ordinarily conduct and their opinions regarding the appropriateness of the treatment that Johnston had provided was sufficient for the jury to determine "the

usual course of medical practice" and to evaluate whether Johnston's practice fell within that standard. Johnston cites various Florida civil and administrative cases in which the Florida courts have examined whether a particular physician's prescription of controlled substances subjected the physician to civil liability or disciplinary action, and she argues that those cases establish that the evidence in this case demonstrate that Johnston's prescription of pain medication to the undercover agents was appropriate given the symptoms that the agents presented to her. Johnston's brief at 31-32. The jury in this case, however, was entitled to find Johnston criminally liable based on the evidence showing that Johnston's prescription of the controlled substances to the agents failed to meet professional standards because she had conducted only the most cursory of examinations on each of those agents before providing them with those substances. During the trial, Johnston even argued that standards of care relating to administrative cases did not apply in this case; objecting to the testimony of one of the United States' expert witnesses, Johnston asserted:

> I'd request an instruction that this witness' peer review for the Department of Health and standard of care is not an issue in this case, but rather, this is being given as part of her qualifications; it may confuse the jury that her review of Dr. Johnston for the Department of Health and her conclusion that she fell below the standard of care from an administrative standpoint may confuse this jury and may mislead this jury

> with respect to the issues in this case, which is criminal.

Doc. 89 at 547-48. (The district court overruled the objection. Doc. 89 at 548.) Regardless of whether Johnston might have faced civil liability or been subject to disciplinary action, Johnston has not identified any authority suggesting that the jury could not have found from the evidence presented that her conduct in these circumstances fell below nationally accepted standards.

In any event, the civil and administrative cases that Johnston cites in her brief are all extremely fact-specific and do not suggest that Florida law would approve Johnston's activities in this case. For example, in Johnston v. Dep't of Prof. Regulation, Bd. of Medical Examiners, 456 So. 2d 939,941-44. (Fla. Dist. Ct. App. 1984), a physician had treated with Dilaudid four patients who suffered from chronic pain. During a disciplinary proceeding in which he was charged with prescribing controlled substances outside the course of his professional practice, he presented the testimony of three board certified expert witnesses, introduced into evidence the Physician's Desk Reference, and testified on his own behalf. Based on this evidence, a hearing officer found that the treatment he had prescribed was reasonable under the circumstances, and the Florida Second District Court of Appeal ruled that this finding was supported by competent, substantial evidence. The opinion does not address the particular deficiency of concern in Johnston's case-namely, the failure to examine and diagnose patients adequately before prescribing powerful narcotics for them. See also Hoover v. Agency for Health Care

Admin., 676 So. 2d 1380 (Fla. Dist. Ct. App. 1996) (addressing standard for administrative board's rejection of hearing officer's findings of fact and not addressing standard of care for examining and diagnosing patients before prescribing narcotics).

Therefore, the Johnston is not entitled to relief from her convictions.

## II. THE DISTRICT COURT DID NOT PLAINLY ERR BY ADMITTING EXPERT TESTIMONY CONCERNING THE "RED FLAGS" INDICATING THAT JOHNSTON'S PRESCRIPTION OF NARCOTICS DID NOT FALL WITHIN NATIONALLY RECOGNIZED STANDARDS.

Johnston asserts for the first time on appeal that the district court should not have permitted the United States' expert witnesses to testify concerning the "red flags" that they had identified in the medical records of the undercover agents that they had reviewed. Claiming that the "red flags" testimony was based on a DEA profiling publication, Johnston disputes that the "red flags" that the experts identified were indicative of drug dealing and illegitimate medical practice. The record establishes, however, that the district court did not plainly err by admitting this testimony.

The term "red flag" first arose during Johnston's cross-examination of the United States' expert witness Richard Hood, who testified that, if a patient told him that he was buying his medication "off the street," "[a] red flag would go up that this

patient that I had been prescribing Roxicodone to is abusing these

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

UNITED STATES OF AMERICA

vs. 2:07-cr-105-FtM-29DNF

SHARON JOHNSTON

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Court's Instructions
to the Jury

Members of the Jury:

It is now my duty to instruct you on the rules of law that you must follow and apply in deciding this case. When I have finished you will go to the jury room and begin your discussions – what we call your deliberations.

It will be your duty to decide whether the Government has proved beyond a reasonable doubt the specific facts necessary to find the Defendant guilty of the crimes charged in the Indictment.

You must make your decision only on the basis of the testimony and other evidence presented here during the trial; and you must not be influenced in any way by either sympathy or prejudice for or against the Defendant or the Government.

You must also follow the law as I explain it to you whether you agree with that law or not; and you must follow all of my instructions as a whole. You

may not single out, or disregard, any of the Court's instructions on the law.

The indictment or formal charge against any Defendant is not evidence of guilt. Indeed, every Defendant is presumed by the law to be innocent. The law does not require a Defendant to prove innocence or to produce any evidence at all; and if a Defendant elects not to testify, you cannot consider that in any way during your deliberations. The Government has the burden of proving a Defendant guilty beyond a reasonable doubt, and if it fails to do so you must find that Defendant not guilty.

Thus, while the Government's burden of proof is a strict or heavy burden, it is not necessary that a Defendant's guilt be proved beyond all possible doubt. It is only required that the Government's proof exclude any "reasonable doubt" concerning the Defendant's guilt.

A "reasonable doubt" is a real doubt, based upon reason and common sense after careful and impartial consideration of all the evidence in the case.

Proof beyond a reasonable doubt, therefore, is proof of such a convincing character that you would be willing to rely and act upon it without hesitation in the most important of your own affairs. If you are convinced that the Defendant has been proved guilty beyond a reasonable doubt, say so. If you are not convinced, say so.

As I said earlier, you must consider only the evidence that I have admitted in the case. The term "evidence" includes the testimony of the witnesses and the exhibits admitted in the record. Remember that anything the lawyers say is not evidence in the case. It is your own recollection and interpretation of the evidence that controls. What the lawyers say is not binding upon you. Also, you should not assume from anything I may have said that I have any opinion concerning any of the issues in this case. Except for my instructions to you on the law, you should disregard anything I may have said during the trial in arriving at your own decision concerning the facts.

In considering the evidence you may make deductions and reach conclusions which reason and common sense lead you to make; and you should not be concerned about whether the evidence is direct or circumstantial. "Direct evidence" is the testimony of one who asserts actual knowledge of a fact, such as an eye witness. "Circumstantial evidence" is proof of a chain of facts and circumstances tending to prove, or disprove, any fact in dispute. The law makes no distinction between the weight you may give to either direct or circumstantial evidence.

Now, in saying that you must consider all of the evidence, I do not mean that you must accept all of the evidence as true or accurate. You should decide whether you believe what each witness had to say, and how important that testimony was. In making that decision you may believe or disbelieve any witness, in whole or in part. Also, the number of

witnesses testifying concerning any particular dispute is not controlling.

In deciding whether you believe or do not believe any witness I suggest that you ask yourself a few questions: Did the witness impress you as one who was telling the truth? Did the witness have any particular reason not to tell the truth? Did the witness have a personal interest in the outcome of the case? Did the witness seem to have a good memory? Did the witness have the opportunity and ability to observe accurately the things he or she testified about? Did the witness appear to understand the questions clearly and answer them directly? Did the witness's testimony differ from other testimony or other evidence?

You should also ask yourself whether there was evidence tending to prove that a witness testified falsely concerning some important fact; or, whether there was evidence that at some other time a witness said or did something, or failed to say or do something, which was different from the testimony the witness gave before you during the trial.

You should keep in mind, of course, that a simple mistake by a witness does not necessarily mean that the witness was not telling the truth as he or she remembers it, because people naturally tend to forget some things or remember other things inaccurately. So, if a witness has made a misstatement, you need to consider whether it was simply an innocent lapse of memory or an intentional falsehood; and the significance of that

may depend on whether it has to do with an important fact or with only an unimportant detail.

When knowledge of a technical subject matter might be helpful to the jury, a person having special training or experience in that technical field is permitted to state an opinion concerning those technical matters.

Merely because such a witness has expressed an opinion, however, does not mean that you must accept that opinion. The same as with any other witness, it is up to you to decide whether to rely upon it.

Count One of the Indictment charges that on or about June 11, 2007, in Collier County, Florida, Defendant Sharon Johnston did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, Oxycodone, and a Schedule IV Controlled Substance, Alprazolam, in violation of 21 U.S.C. §841(a)(1) and §841(b)(1)(C).

Count Two of the Indictment charges that on or about June 27, 2007, in Collier County, Florida, Defendant Sharon Johnston did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, Oxycodone, in violation of 21 U.S.C. §841(a)(1) and §841(b)(1)(C).

Count Three of the Indictment charges that on or about July 5, 2007, in Collier County, Florida, Defendant Sharon Johnston did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule IV Controlled Substance, Alprazolam, and a Schedule II Controlled Substance, Methadone, in violation of 21 U.S.C. §841(a)(1) and §841(b)(1)(C).

Count Four of the Indictment charges that on or about July 10, 2007, in Collier County, Florida, Defendant Sharon Johnston did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, Oxycodone, in violation of 21 U.S.C. §841(a)(1) and §841(b)(1)(C).

Title 21, United States Code, Section 841(a)(1) makes it a Federal crime or offense under some circumstances for a physician to knowingly and willfully dispense a controlled substance.

The Defendant can be found guilty of the offenses of unlawfully dispensing controlled substances as charged in the Indictment only if all of the following facts are proved beyond a reasonable doubt:

First: That the Defendant dispensed the controlled substances named in the Indictment; and

Second: That the Defendant dispensed the controlled substances knowingly and willfully; and

Third: That the Defendant dispensed the controlled substances outside the scope or usual course of professional medical practice.

Oxycodone, Alprazolam, and Methadone are each a "controlled substance" within the meaning of the law. In the context of this case, the term "dispense" means to deliver a controlled substance to an ultimate user by or pursuant to a prescription of a physician.

Defendant is not on trial for medical malpractice and is not charged with acting negligently with respect to the care of her patients. Rather, she is charged with knowingly and willfully prescribing controlled substances to her patients outside the usual course of professional medical practice. To determine the "usual course of professional medical practice" you may consider the totality of the circumstances, including evidence of accepted professional standards of care and expert testimony.

Defendant's position is that at all times she acted in good faith and in accordance with the standard of medical practice generally recognized and accepted in the United States while treating her patients. A physician's good faith is relevant to determine whether the physician acted outside the range of professional medical practice.

A controlled substance is lawfully prescribed by a physician if (1) the physician is lawfully licensed to practice medicine, (2) the physician is registered with the Drug Enforcement Administration, and (3) the controlled substance is prescribed by the physician in good faith as part of the physician's medical treatment of the patient in accordance with the standard of medical practice generally recognized and accepted in the United States. Objectively honest efforts to prescribe controlled substances in compliance with the accepted standard of professional medical practice are not criminal. On the other hand, a physician's mere subjective personal belief that she is meeting a patient's medical needs by prescribing a controlled substance is not sufficient to show good faith if the physician acts outside the accepted standard of medical practice in the United States.

The Government must establish beyond a reasonable doubt that the Defendant acted outside the usual course of professional medical practice, as charged in the Indictment, and that her actions were not done in objective good faith. The burden of proof is not on the Defendant to prove objective good faith, since the Defendant has no burden to prove anything.

The Defendant has offered evidence of the Defendant's traits of character, and such evidence may give rise to a reasonable doubt.

Where a Defendant has offered testimony that the Defendant is an honest and law-abiding citizen, the jury should consider that testimony, along with

all the other evidence, in deciding whether the Government has proved beyond a reasonable doubt that the Defendant committed the crime charged.

As you have heard, Exhibits 4 and 6B have been identified as typewritten transcripts of the oral conversations that can be heard on the recordings received in evidence as Exhibits 2 and 6A. The transcripts also purport to identify the speakers engaged in such conversation.

I have admitted the transcripts for the limited and secondary purpose of aiding you in following the content of the conversations as you listen to the recordings, and also to aid you in identifying the speakers.

However, you are specifically instructed that whether the transcripts correctly or incorrectly reflect the content of the conversations or the identity of the speakers is entirely for you to determine based upon your own evaluation of the testimony you have heard concerning the preparation of the transcripts, and from your own examination of the transcripts in relation to your hearing of the recordings themselves as the primary evidence of their own contents; and, if you should determine that the transcripts are in any respect incorrect or unreliable, you should disregard them to that extent.

You will notice that the Court Reporter is making a complete stenographic record of all that is said during the trial, including the testimony of the witnesses, in case it should become necessary at a

future date to prepare printed transcripts of any portion of the trial proceedings. Such transcripts, however, if prepared at all, will not be printed in sufficient time or appropriate form for your review during your deliberations, and you should not expect to receive any transcripts. You will be required to rely upon your own individual and collective memory concerning what the testimony was.

On the other hand, any papers and other tangible exhibits received in evidence during the trial will be available to you for study during your deliberations.

You will note that the Indictment charges that the offenses were committed "in or about" and "on or about" certain dates. The Government does not have to prove with certainty the exact date of the alleged offense. It is sufficient if the Government proves beyond a reasonable doubt that the offense was committed on a date reasonably near the date alleged.

The word "knowingly," as that term is used in the Indictment or in these instructions, means that the act was done voluntarily and intentionally and not because of mistake.

The word "willfully," as that term is used in the Indictment or in these instructions, means that the act was committed voluntarily and purposely, with the specific intent to do something the law forbids; that is with bad purpose either to disobey or disregard the law.

A separate crime or offense is charged in each count of the indictment. Each charge and the evidence pertaining to it should be considered separately. The fact that you may find the Defendant guilty or not guilty as to one of the offenses charged should not affect your verdict as to any other offense charged.

I caution you, members of the Jury, that you are here to determine from the evidence in this case whether the Defendant is guilty or not guilty. The Defendant is on trial only for those specific offenses alleged in the indictment.

Also, the question of punishment should never be considered by the jury in any way in deciding the case. If the Defendant is convicted the matter of punishment is for the Judge alone to determine later.

Any verdict you reach in the jury room, whether guilty or not guilty, must be unanimous. In other words, to return a verdict you must all agree. Your deliberations will be secret; you will never have to explain your verdict to anyone.

It is your duty as jurors to discuss the case with one another in an effort to reach agreement if you can do so. Each of you must decide the case for yourself, but only after full consideration of the evidence with the other members of the jury. While you are discussing the case do not hesitate to reexamine your own opinion and change your mind if you become convinced that you were wrong. But do not give up your honest beliefs solely because the

others think differently or merely to get the case over with.

Remember, that in a very real way you are judges – judges of the facts. Your only interest is to seek the truth from the evidence in the case.

When you go to the jury room you should first select one of your members to act as your foreperson. The foreperson will preside over your deliberations and will speak for you here in court.

A form of verdict has been prepared for your convenience.

[Explain verdict]

You will take the verdict form to the jury room and when you have reached unanimous agreement you will have your foreperson fill in the verdict form, date and sign it, and then return to the courtroom.

If you should desire to communicate with me at any time, please write down your message or question and pass the note to the court security officer who will bring it to my attention. I will then respond as promptly as possible, either in writing or by having you returned to the courtroom so that I can address you orally. I caution you, however, with regard to any message or question you might send, that you should not tell me your numerical division at the time.

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

UNITED STATES OF AMERICA

| | |
|---|---|
| v. | CASE NO. 2:07-cr-105-ftm-29dnf |
| SHARON JOHNSTON | 21:841(a)(1)<br>21:841(b)(1)(C) |

**INDICTMENT**

The Grand Jury charges:

**COUNT ONE**

On or about June 11, 2007, in Collier County, in the Middle District of Florida, the defendant herein,

SHARON JOHNSTON,

did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, to wit: Oxycodone, and a Schedule IV Controlled Substance, to wit: Alprazolam, in violation of Title 21, United States Code, Sections 841(a)(1) and 841(b)(1)(C).

**COUNT TWO**

On or about June 27,2007, in Collier County, in the Middle District of Florida, the defendant herein,

SHARON JOHNSTON,

did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, to wit: Oxycodone, in violation of Title 21, United States Code, Sections 841(a)(1) and 841 (b)(1)(C).

**COUNT THREE**

On or about July 5,2007, in Collier County, in the Middle District of Florida, the defendant herein,

SHARON JOHNSTON,

did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule IV Controlled Substance, to wit: Alprazolam, and a Schedule II controlled substance, to wit: Methadone, in violation of Title 21, United States Code, Sections 841(a)(1) and 841(b)(1)(C).

**COUNT FOUR**

On or about July 10, 2007, in Collier County, in the Middle District of Florida, the defendant herein,

SHARON JOHNSTON,

did knowingly and willfully act outside the scope of professional practice by dispensing quantities of a Schedule II Controlled Substance, to wit: Oxycodone, in violation of Title 21, United States Code, Sections 841(a)(1) and 841(b)(1)(C).

A TRUE BILL,

Dated: 8/29/07 /s/
Foreperson

JAMES R. KLINDT
Acting United States Attorney

By: /s/
Douglas Molloy
Chief Assistant United States Attorney
Trial Counsel

FORM OBD-34
APR 1991 No.

UNITED STATES DISTRICT COURT

Middle District of Florida
Fort Myers Division

THE UNITED STATES OF AMERICA

vs.

SHARON JOHNSTON

INDICTMENT

Violations:

21 U.S.C. §841(a)(1)
21 U.S.C. §841(b)(1)(C)

A true bill,

/s/
Foreperson

Filed in open court this 29th day of August, A.D. 2007.

Clerk

Bail $_____